NATIONAL COMMISSION ON VA NURSING

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BEFORE: MARILYN PATTILLO, Ph.D., Chairperson
JOHN DANDRIDGE, Member

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APRIL 16, 2003

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Hearing in the above matter was held at the RADISSON-PLAZA WARWICK HOTEL, 1701 Locust Street, Philadelphia, Pennsylvania 19103, beginning at 8:30 a.m., before McKinley Wise, a Registered Professional Reporter and an approved Reporter of the United States District Court.

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DR. PATTILLO:

Good morning. I am Dr. Marilyn Pattillo and I am the chairperson for the National Commission on VA Nursing. Seated with me is John Dandridge. Let me tell you about Mr. Dandridge. Mr. Dandridge is the network director for VA Midsouth Health Care Network Division 9, Nashville, Tennessee. He is the past CEO of United Health Care Systems and Children's Hospital in New Jersey, and he is also on the commission.

MR. DANDRIDGE:

Good morning to everyone.

DR. PATTILLO:

And we also have Bob Swanson. Bob Swanson is part of our commission staff and he is the program analyst, office of management support, central office VHA. We also have Donna Schroeder who you met coming in. She's the human resource specialist, office of the human resources, the central office. I just want to introduce to you also Rita Moore who you have met earlier. She's our executive director, if you will, of our commission and a little bit of her background. She's a past nurse executive, nursing service, VA Medical Center in Washington, D. C. Now, our court reporter is Mac Wise. And we have Kurt Gallagher. He is going to be taking some pictures for AFGE. I would like to give you just a brief background of the commission, its tasks and its progress to date. I forget to introduce to you, me. Let tell you my background. I'm the commission chair and I'm a professor at the clinical nursing at the University of Texas at Austin. I'm here because of school affiliation but also I'm a Colonel of the United States Air Force Reserves, retired. And I'm also a nurse practitioner, a clinical nurse specialist I have a very strong clinical practice as well as teach. So I just wanted to let you know that about my background. The commission was established by the Congress and appointed by the Secretary of the Department of Veterans Affairs. The duties of the commission are, as follows: organizational policy changes to enhance the recruitment and retention of Consider the legislative and nurses and other nursing personnel by the Department of Veterans Administration, veterans affairs, assess the future of the nursing profession within the department and we are also going to make recommendations, legislative and to enhance the organizational policy changes recruitment and retention of nurses and other personnel in the department. A twelve-member commission of VA and non-VA staff as designated by Congress, and it was appointed to carry out this charge. The first meeting of the commission was held May 8, 2002.Since the May 8th meeting the commission has held three additional meetings. During this time the commission is using various methods to obtain feedback from VA Nursing staffs, in order the make assessments. The commission will submit an interim report in July of 2003. A complete report will be submitted to the Secretary of the Department of Veterans Affairs, May2004. The secretary will then have 60 days to submit to Congress a report providing the secretary's views on the commission's finding and recommendations, explaining what actions, if any, the secretary intends to take to implement the recommendations of the commission and the secretary's reasons for doing so. The purpose of this hearing is to obtain input from VA Nursing staffs on recruitment and retention issues. The commission places a high priority on obtaining feedback from all levels of VA staffs. Over the coming months, the commission will continue to gather data and to hear from VA staffs. We encourage you to visit our Web site at WWW.VA.GOV/NCVAN. For e-mail to the commission at VHACONCVAN@HQ.MED.VA.GOV. Now we've a little flier out in the front there outside if you need to get this e-mail address. Having given that brief background we will move to the agenda forward by laying ground the rules for conducting the hearing and answering anything questions concerning this process that you may have. The commission is here to listen and realizes that testimony is presented from the view of the presenter and may contain please inaccurate information. Therefore, understand that any

misstatements regarding VA policies/regulations will be addressed at a later time. In order to facilitate a smooth process and to allow as many people to speak as possible within the time frame, the following guidelines will apply: Those of you who are scheduled to provide testimony will take no longer than10 minutes. Witnesses will be cautioned with a yellow flag card and when there is three minutes left to give testimony and witnesses will be notified with a red card when time is up. I will also call that time. When time is up witnesses will promptly stop talking and leave the table unless the commission members have questions, and we'll have questions to clarify, if there are some things that we need to ask you. To expedite presentations please note where your name is on the list. And in terms of the open forum we have added some more slots for open forum. The open forum sessions are really -- we will start at 9:40 and I will have a list of people who have signed up, first come, first served and there are various times during the day but our major open forum is this morning and then later on this afternoon. Speakers in the open forum will have three minutes to address he commission members. Speakers will be notified again with a red card when the time is up. And when the time is up, speakers will promptly stop talking and return to their places in the audience. Presenters who do not use the allotted time to speak may not offer remaining time to another presenter. So you have to have signed up. First come, first served just to make it fair for everybody. Now, I want to thank all of you coming. I know some of you have come at your own expense. So, we really, really appreciate your taking the time away and to come and to address us. Again at end of the hearing, if you have any insight based on what everybody said you can certainly still connect with us, e-mail us, give us your perspective. We did a hearing in New Orleans and we'll do one in Chicago next week and then Los Angeles the following week.

VOICE:

When we come back from lunch we will move to the Walnut room. We'll move lunch into a bigger room.

VOICES:

Thank you.

DR. PATTILLO:

I appreciate the work of the staff in putting this all together. We have received over 500 written testimonies trying to organize all this and get it all out to the commission members. It has been challenging but we will do our best. We really appreciate you being here. So let's get started. We are just a little bit behind but we will you give the 10 minutes. Are there any questions as to how we're going to deal with the day. Let's start. Karen Leon.

MS. LEON:

Good morning. My name is Karen Leon I'm a registered nurse at the Clarksburg, West Virginia Veterans Hospital. I have a BSN and a Master's degree in community health from West Virginia University. I have worked at the veteran’s hospital for 14 years, in all areas of our hospital: the medical/surgical wards, ICU, psychiatric ward, emergency room, and specialty areas. And for now, for the past

five years I'm working in the primary care. I'm addressing the qualification standards and grade level questions. Most registered nurses at the VA are into direct patient care and patient education. And they plan to stay in that capacity. I have worked in the private sector and I believe that our veterans are the best patients and deserve the best nurses to give them their education and care. I want to stay in direct patient are utilized every day to provide this care and education to our veterans. I'm a member of our professional nursing board that meets every month and observe registered nurses being denied raises and to the Grade III level because of the subjective high quality standard grade levels. To make the Grade III level standard the registered nurse must have a Master's degree in nursing and program experience or management positions. There are limited usually management positions available and don't involve direct patient care. As I stated before, most registered nurses want to stay in that capacity as I have. I do not qualify for this Grade III position because I plan and choose to stay in direct patient care. Other RNs in our hospital do have program experience but are denied this Grade III level because they do not have management positions. I believe the qualification standards and grade levels are unfair and need to be revised, so that these raises for the individual registered nurse that have the experience to be given a Grade III position, not be penalized due to their non management positions and their desire to stay in direct patient care. I would like to give the commission an overview of the nurses that work in our veteran's hospital. We take care of our fathers, our brothers, uncles and sons. We look forward to taking care of our new veterans who are fighting now in our Iraqi freedom. I plan to stay and retire at the veteran's hospital. Thank you.

DR.PATTILLO:

Any questions?

MR. DANDRIDGE:

No.

DR. PATTILLO:

Thank you very much, Karen.

DR. PATTILLO:

MR. LEE.

MR. LEE:

Good morning. My name is Vinny Lee and I'm staff nurse at Northport VA. Educational wise I have a BSN from Hunter-Bellevue and an MSN in genealogy from Suny Stonybrook. I have been professional nurse times 23 years and have over 16 years experience with the VA. First I want to say what a privilege it is to appear before this commission in morning. I want to discuss some issues that are now near and dear to us nurses. In addition I want to commend this for your reference in correcting some of the commission deficiencies in the VHA. We nurse cherish the duties we have to care for our veterans and for those that are continue to sacrifice their

lives in Iraq at this moment. I wish to talk about four issues: staffing, mandatory overtime, premium pay and the nursing professional standards board. Inadequate staffing of health care workers in the VA is threatening veterans act system and high quality patient care. During the past five years the veterans health administration has cut over 20,000 employees or nine percentage of its health Care work force. Direct patient care staff such as nurses make a significant number of staffing losses. The number of RNs and LPNs at the VA increased just barely at 1.3 percent and 0.1 percent, respectively, even though VA staff is treating more and more veterans who are older and sicker. Given these significant cuts in staff it is really surprising that the VA has backlog of more than 260,000 veterans who have wait an average of six months for their first appointment a VA facility with another 164,000 veterans who are expected to enroll for care this current fiscal year2003. The VA's failure to adequately staff VA medical facilities, outpatient clinics and long term care facilities has hurt veteran's access to care. Research indicates that lack of adequate health care staff also has an adverse impact on quality of patient care and patient outcomes. Surgery patients have a greater chance of dying after a procedure because they have a heavier patient workload. Medical patients received a high proportion of RNs providing care and increased hours of RN care at lower rates of UTIs or urinary tract infections, upper gastrointestinal bleeding and cardiac arrests. High use of nurses who flow from unit to unit rather than regular staff nurses places patient at increased risks for bloodstream infections. Patients who have surgery done in hospitals with fewer RNs per patient than other hospitals run a higher risk of developing avoidable complications following their operations. Hospitals that provide one more hour of nursing care for patient day at almost 10 percent fewer patients with urinary tract infections and eight percent fewer patients with pneumonia. Ordering to bed ratio was the most important factor in predicting the difference among hospital success rates in saving patients who experience serious adverse effects. Adequate staffing levels is also pivotal to retaining and recruiting nursing staff during the current nursing shortage. Nurses in understaffed hospitals are more likely to experience burn out, job dissatisfaction, and leave their jobs. VA nurses and VA management should have the opportunity to negotiate safer staffing level. Despite extensive research that links increased staffing levels to better patient outcomes, the VA have very little say over adequate staffing level at the VA. The commission should recommend to Congress to change the law to allow nurses representatives the opportunity to sit down with VA management and come to agreements about ways to ensure safe and adequate staffing levels and improve direct patient care to our veterans. As a side note. Only while performing active duty in the Army Nurse Corp in various hospitals throughout the United States, was I as an RN really able to practice being an RN where I had time because of all the ancillary staff that you usually get in an Army hospital. I'm sure you found that in the Air Force situation. And I had a new diabetic who was going home on insulin I could sit down and spend an hour and do real in-depth teaching. In the environment we work in today not only in the VA, not just as a scapegoat in the VA but in proprietary hospitals too, there is no time. It is so much paperwork, inundated with paperwork and managers seem to be more important with getting the paperwork done than getting the patient safe and effective care, and they would stay home longer, too, if they get discharged properly. And I'm sure the VA would like to do this, too, also but we're all victims of regulations and legislation and in a proprietary hospital if they wanted to make some changes they can just go to the board of directors and see if there is money in the budget and act. Our hands

are tied not only the staff but the management of the VA facilities. That is why we're so dependent on Congress to help us out here. Mandatory overtime. Mandatory overtime as a means of staffing is contrary to patient safety. Without adequate nursing staff more facilities are relying upon overtime to staff each unit. Where the nurses are pressured or mandated to work a double shift quality of care suffers. The cumulative impact of VA's us of the mandatory overtime is that nurses and other staff are overworked, overwhelmed and fatigued from working too many hours day after day. The use of mandatory overtime as a means of staffing is a practice that reflects a weak commitment to patient safety. Weary and exhausted nurses lack the keen level of concentration and emotional stamina necessary to deliver high quality and compassionate care. Medications, basic care and critical medical intervention will be delayed, forgotten or mixed up because the staff is tired and being spread too thin. Mandatory overtime usually occurs on wards that are really operating at reduced or unsafe staffing levels. The use of mandatory overtime is a shortsighted response to inadequate staffing because it worsens the staffing problem, places patients at risk and puts extraordinary burdens on direct patient care and staff. The commission should recommend that the VA establish a nationwide policy prohibiting the use of mandatory overtime. And when you staffs real thin have no wiggle room, you can't tolerate any call ins or anything and you end up with a overtime situation and everything else. In our facility we need to bring back like a float team or something which we used to have and we don't have that now. There is no wiggle room and a weather emergency like snow in the northeast. We get snow. There is no wiggle room and some people spend 48 hours, 72 hours in the hospital. VA does put them up and feed them but big deal. I mean they are burnt out at times. Premium pay. Highly specialized areas such as ICU, OR, dialysis should have premium pay as an improvement incentive. Night nurses are difficult to retain and it would help if increased premium pay were offered. At our facility our chief nurse was even looking into that but due to regulations she cannot do that. There is no way to do that. Charge nurses who assume the role of head nurse during winter hours when they are not there should also be some ability to give them some extra money. I have worked in proprietary hospitals and usually if they put an asterisk next to your name you're in charge and you get $10, $15, $20 extra or couple dollars extra an hour for that responsibility. You can give leave. There is plenty of things you do but give something. Right now there is nothing for that responsibility. Pay grade should be continuous, so that nurses don't become stagnant at one pay grade. So you can reward for longevity. Many work environment prior to becoming a nurse and other venues where I've worked people get something for longevity, something for long hard years of service, not frozen and not in the case where somebody might get hired with zero experience and be making the same money as somebody that has 20, 30 years of faithful service. There is no provision for that at all. That is it.

DR. PATTILLOI:

That is you Mr. Lee, but before you leave I have some questions.

MR. DANDRIDGE:

I have some.

DR. PATTILLO:

Go ahead.

MR. DANDRIDGE:

I would like Mr. Lee to clarify his previous comment in reference to premium pay. You made a statement due to regulations there was some restrictions or limitations that you were describing. I didn't quite understand that.

MR. LEE:

Well, there evening and night differentials which is the same. Evenings and nights get the same exact pay. But at our facility we've have a lot of trouble retaining and recruiting night nurses. So even our chief nurse was looking into rewarding them somehow with some kind of benefit, you know, to increase the night nurses and our hands are tied, cannot do it because of regulations.

MR. DANDRIDGE:

I kind of got the impression that you were insinuating that in certain situations where a nurse might be asked to work overtime they may not be entitled to the premium pay. Is that what you were alluding to?

MR. LEE:

No. That was an earlier issue. Mandatory overtime.

DR. PATTILLO:

You know the research that you cited. That is research outside the VA; right?

MR. LEE:

Yes.

DR. PATTILLO:

Linda Akins, University of Pennsylvania work. Any kind of research within the VA that links nursing practice with patient outcomes, nursing staffing with patient outcomes? Do you know of?

MR. LEE:

Not off the top of my head but I definitely could provide you -

DR. PATTILLO:

Wouldn't that be neat if we had that data, too; right?

MR. LEE:

We don't have the data.

DR. PATTILLO:

Yes, and I think that is an opportunity in the future for us to validate our practice. When I say "our," because I'm with you, you know. And the only thing is I read your written testimony you submitted. You said that some part-time nurses cannot be allowed to become permanent. Is that true

MR. LEE:

Part-time nurses are temporary in the VA. And if there was a reason for a reduction in force, regardless of veteran's status or years of service, they would be gone. They are not permanent employees. Part-time employees that work on .05 and less have to pay more for their health benefits than full-time employees. That's an injustice. That is all stupid laws by men when they designed them but people got caught in the cracks.

MR. DANDRIDGE:

There is no limit or time frame in which an individual could remain in a part-time slot?

MR. LEE:

If they were there 30 years they are still like a temporary employee. It is my understanding of the law.

DR. PATTILLO:

The other question I have for you is in terms of you said that advertising may advance that the VA has accomplished and market the same to perspective candidates. Because you didn't know the wonderful things that VA does, but seems to not be visible to the rest of the world.

MR. LEE:

I didn't get to that yet but I wanted to mention BCMA, CPRS people
Who are really computer literate today and it could be attractive to young people if we could market that.

DR. PATTILLO:

I would be interested to know how would you do this; how could you raise the visibility of nursing advances to all levels at the facility level, the network level and the central office? You don't have to answer now,

MR. LEE:

If you hire me as a consultant I'll look into it.

DR. PATTILLO:

If you have any ideas -- if you have any ideas -- and all of you, if you have any idea please do write this down. Because I do think we have that opportunity now to see the wonderful things that you do and let those things speak in your favor. Well, thank you so much. Thank you very much.

MR. LEE:

Thank you.

DR. PATTILLO:

Next is Rosie Edwards.

MS. EDWARDS:

Good morning, everyone. My name is Rosie Edwards. I'm from St. Albans Extended Care Center. I'm working there for twenty-and-a-half years. I can't say it is not a good place to work. It is a good place to work but we do have some issues and I would like state to you a few of the issues that is my concern. The VA does not have the incentive to attract and retain skilled nursing or NAs. Opportunity and advancement are limited. To have a resounding yes would be to recognize workers that are successful in their jobs. When I speak of that I speak of people that has been there for a long time that is trying to pursue further. I'm in school for my RN. There is not a great opportunity money wise to send you to school. You know, they do not try to help you. To recognize workers that are achievement should come into play. Encourage one to flourish. It is important that NAs and all staff are treated fairly and give recognition and support that they deserve. Nurses in the VA facility do not control staffing, quality improvement and peer review. Changes that could be made that would improve would be to allow all nursing staff including NAs in the decision-making. Staffing should not only look good on paper. Allow staff that takes care of residents to talk about the amount of staffing that is needed for quality care. There should be a legislation move because of insufficient staff. Trust can be better-established and maintained between nursing staff and nursing administration. Number one, listen to your staff, allow them to have a voice. They are decision makers. All nursing staff should participate in decision and problem solving. NAs and health techs are the backbones on the floor Their ideas are used all over the world. Their training, things that helps the RNs, the doctors, everyone. Often they are considered as low skilled employees. NAs and health techs have no voices in the decision or problem solving, units level or organization level. Some of the issues of concerned in the VA are premium pay. Nursing assistants and others are not paid Saturday premium. This is unfair. We work as a team. Everyone should be treated equally whether you are a housekeeper or a whether you are an NA or RN, everybody should be treated the same. Everyone should be treated equal. The law should be changed to guarantee all employees equal employment. Our goal is to reach for the moon and if we fail we still want to be among the stars. NAs work hard to make sure quality care is given at their facility, even when they are short on staff. However you're not able to get your certification renewed. We pray for a change in power. A line legislation to make a new law. Support this difficult problem. Also allow the NA, health techs; maybe support the grandfather clause to give these people a chance to further their education. You know, we have people here 20 years, some less but we would do good as LPNs and RNs. Allow them a chance to move up, and recognize the work that they have done. Thank you.

DR. PATTILLO:

I enjoyed reading your testimony, Rosie.

MS. EDWARDS:

Thank you very much.

MR. DANDRIDGE:

I don't want to be redundant but I continue to hear comments about the premium pay and I guess I need a better understanding Your testimony indicates that nursing assistants and others are not eligible to receive premium pay irrespective of the shifts that they work that he work.

MS. EDWARDS:

Well, the premium for Saturday and Sunday I'm concerned about because only the RNs, now we have the LPN that's getting Saturday and Sunday premium. The health techs, kitchen workers we don't receive it. And my thing is this is unfair. I leave my family just like the RNs. So do the housekeepers. Everybody should be treated equal. Maybe not the same amount of money but what little I'm due I should get it.

MR. DANDRIDGE:

Thank you.

DR. PATTILLO:

Next is Bethany McIvor.

MS. McIVOR:

Good morning. My name is Bethany McIvor. I'm an RN with the BSN from the I'm a recovery room nurse and I have had the University of Iowa. honor taking care of the veterans at the Boston VA for 16 years now. In our facility I believe top management has moved to include nurse executive more and more in decision making and rightfully so. I believe our inclusion of nurse executives in decision-making is a good move. However the care-givers, the actual care-givers, the people who have the knowledge of the day to day operations of their unit are completely cut out of decision making. In fact, I believe that Title 38 employees are intentionally cut out of the decisions having to do with staffing and practice issue. The staffing methodology currently used at the VA works pretty well under ideal and other types of occupations though it doesn't really adapt. Nurses are running around the hospital looking for stretchers, we're emptying garbage, we're answering telephones, we're arranging transportation. So when these ancillary position are left vacant that staffing formula that's used to say how many nurses per patient the formula falls apart and crumbles and nurses retention, it doesn't help moral. I also don't know of any staffing methodology for outpatient workload. So we have our clinic visits that are doubled or triple booked meaning three veterans for the9:00 a.m. time slot. Nurses feel they have no say in how much they can physically and mentally handle, getting that message across. Nurses in Boston are join together in a union to have greater influence in the workplace, and they elect representatives like myself to be their voice. Silencing staff nurses is not good for patient care and it is not good for recruitment and retention. As an example our outpatient Endoscopy unit in Boston is incredibly busy. We have huge backlog. We want to do as many cases as possible because we know early detection of colon cancer is the key to

saving lives. This winter we went down two RNs and three technician positions. What happened was the RNs did over the same number of cases even though it was reduced. It was same number of cases. So the RNs did double duty. This picked up the technician's jobs, they started washing and sterilizing scopes. We transmit the equipment ourselves back and forth between our two facilities. The nurses came to me and some of them were in tears, actually crying saying, I can't take this anymore. Can you help us? So what they were asking for was the union to advocate them and their patients because they felt that the patients weren't getting the best care. They are also doing mandatory overtime, which added to their stress. Being cut out of decision making these nurses had approach the nurse manager and they had great ideas about how to make the unit more efficient, and how make it more patient friendly and those ideas were ignored. Being cut out of decision making leads to feelings of hopelessness and it alienates you from the health care team. The nurse manager told me it was a patient care issue and a staffing issue and not a union issue. This notion that union is forbidden under Title 38 from proposing anything having to do with patient care is ridiculous and it is promoted by VA management. We're working in a hospital . We're taking care of patients. We're nurses. What else are we as concerned about as patient care? So I also represent Title 5 professional employees: psychologists, social worker, other therapists and there are no restriction on proposals that arise out of patient care or clinical competency for these professionals. For nurses these issues are off the table. I'm asking that you give us the statutory tools to be able to sit down with nursing leadership and work together to make decisions that will benefit our patients, allowing front line employees and union representatives a chance to be involved in decision making even clinical decision making can only help veterans, it can't hurt it. I understand the commission has heard a lot about the professional standards board and that in the eyes of the VA Nurses it lacks a certain credibility. I'm going to skip over some things I included in my written testimony. But my strongest recommendation concerning the board is to allow nurses to negotiate a fair, more consistent, independent procedure for the peer review process. We don't want negotiate over who gets a promotion and who doesn't get a promotion but the procedures of the process. To many nurses the professional standards board and the qual standards are a mystery. Our unions helped to de mystify that process by educating them about the qual standards. We sat down with our members and actually helped them write their proficiencies, which many of them weren't doing. In February after serving on the board for four years, the union representatives were told by the nurse executive that we were being kicked off the board because VA management now is broadly interpreting Title 38 section 7422 and because it was peer review even though we weren't negotiating or we weren't reading anything we are were asked to leave. Another concern I have is the specific education requirement, which we have already heard about, but the impact or ability to recruit also. VA now can only bring in an RN who doesn't have BSA is going to come in as a Nurse I, whether they have5, 10, 15 years of experience. They are going to be a Nurse I. In Boston they can go a mile down the road and go to any of five or six fabulous hospitals who will gladly take them and gladly pay them what they are worth. So, it is our loss. It is VA's loss. Over the years I have come to the realization and I didn't start out this way that it is not necessary for a staff nurse to have a BSN. I'm glad I got my BSN and I believe my liberal arts education benefited but whether a lack of BSN makes a lesser staff nurse is questionable. I don't think it is true. There is a serious moral problem within the VA. However, I'm very proud of the fact that no matter how

discouraged VA nurses are with their jobs our patients continue to give us the highest praise and customer satisfaction keeps rising and VA is a national leader in many health care initiatives. This is a testament to the dedication and devotion that VA nurses have for their patients. We may be frustrated with our jobs but we absolutely love our work. In summary, VA nurses and their unions need to be given the same tools that other VA professionals have in decision making over patient care related issues. VA management is now using an increasingly broad interpretation of the Section 7422 of Title 38 in order to exclude front line VA doctors and nurses from decision-making. 7422 was inserted by Congress in Title 38 to give nurses more collective bargaining rights and now it is being used against us. VA nurses should also be allowed to grieve pay related issues. If a nurse loses six months to a year and this is not unusual of a higher pay scale because of the mess up at the board or a piece of paper that didn't get filed, they have no where to go with that. They can't get that money that's rightfully owed them. This leads the frustration with the system and you lose trust in the institution. Allowing unions to negotiate fair procedures surrounding peer increase nurse satisfaction, trust and review will ownership in the process, making it a true peer review process. I also feel having a third party appeals process for board action will give legitimacy to the board. If everything is as is it should be what's the fear having it looked at again? Again filling the ancillary and staff vacancies help nurses and helps patient care. I also strongly believe as, Ms. Edwards said, any Title 5 employee works a weekend should get weekend premium pay just like our RNs and LPNs do. I would like to recommend that each facility have a mandatory overtime task force that analyzes overtime, figure out why it happened determine the cause, develop a plan to alleviate it and include staff nurses on that task force. My last recommendation is that an employee awards and recognition become part of the nurse manager's performance evaluation. There is no accountability for first line supervisors, this is where the problem is mostly, who year after year refuse -- decades some of the them -- to participate in an award program. Being a public employee and helping our country fulfill its mission to veterans is an honor. VA employees know we're part of something good. Thank you. Any questions?

DR. PATTILLO:

I think you answered the question that I had. You said you are ignored and I say ignored by whom and I'm thinking it could be the first line nurse managers who need a lot of training.

MS. McIVOR:

Right. I had to go up all the way up to the nurse executive.

DR. PATTILLO:

Okay.

MR. DANDRIDGE:

I picked up on that as well. Also I guess I wanted some clarification. You are being asked to not participate in the board process was a local decision. Also I guess I wanted some clarification. You are being asked to not participate in the board process was a local decision.

MS. McIVOR:

It was issued from central office to our nurse manager. Our nurse executive said she had no problem being with them and found it beneficial and her hand was forced by top management in central office.

DR. PATTILLO:

Can I ask who in central office? Central office is big.

MS. McIVOR:

You want to know? It was Audrey Drake. You asked me. I'm telling the truth.

MR. DANDRIDGE:

That is what we want, yes. Also, you noted a couple of times as well as others the importance of having the opportunity to have input in unit staffing level requirements. Is it your belief that the only way to address that is through the legislative authority or the other tools that you believe would be helpful or would be representative of being inclusive in a participatory staffing determination process.

MS. McIVOR:

I think it has to be legislative just because the Title 38 Section 7422 that's sort of black and white. If it could be an elective, if management could elect to bargain over it, make it be a permissive topic. They may not be mandated to bargain with the union over it but they need some flexibility to choose to, if they want to.

MR. DANDRIDGE:

Thank you.

DR. PATTILLO:

Thank you very much.

DR. PATTILLO:

We have time for three open mike testimonies. The first one is Sandra Cary.

MS. CAREY:

My name is Sandra Carey. I'm a registered nurse. I have worked on the surgical floor for 30 years. Taking care of our veterans has always been top priority for me especially more so because I have a brother and two nephews in Iraq. Too many our excellent nurses leave because there is no potential for promotion. There are many lawsuits that have been initiated because of the blatant disregard of the federal regulations. There have been cases of records being purged. Performance evaluations rewritten by other than immediate supervisors and some top decisions for review without the individual's knowledge or consent. How many more lawsuits are going to be settled and how many more will be filed before some positive action is taken to hire and retain our good nurses? In this regard we rarely know

about the deficiencies that are going before the board and we don't even know what standards are being interpreted. Thank you.

DR. PATTILLO:

Where are you from?

DR. PATTILLO:

Thank you so much. Tracy Pavetti.

MS. PAVETTI:

My name is Tracy Pavetti and I am a licensed practical nurse. I have been serving veterans at the Pittsburgh VA health care system for 10 years. I currently work in the emergent care center. On any given day in my department there may be only three nursing staff working with five doctors. Who has ever gone to a doctor's office on a sick call and have three nurses for five doctors. We serve 30 to 60 veterans on the daylight shift alone. The emergency room lacks ancillary staff. There are no phlebotomists to draw blood, the respiratory techs to administer breathing treatments, no health technicians to perform EKGs, no escorts to transport patients and no nurse assistants to provide basic patient care. The three nurses on duty must provide all of these services in addition to all of their routine duties. This causes unnecessary delays in the treatment of veterans. A veteran with a non acute problem can and will wait two to six hours until treatment is provided. The emergency department has become overrun with veterans who requesting the most basic services. They have a cold. They have run out of medications. They are unable to reach their doctor or they just want to be seen by a doctor. As the acute level of each patient increases more skilled services need to be provided. If lab work is needed the nurse must draw the blood, and that is not always an easy task and hand-carried down the hall and up two flights of stairs to drop it off for processing. This leaves that area of the emergency room department unattended. Patients frequently must go to radiology or the vascular lab for diagnostic testing. If the nurse must escort them it leaves an area of the emergency department unattended. If a wheelchair is needed a nurse may spend 10 to 20 minutes just obtaining that. When a veteran has completed testing they're expected to return to the ER on their own. Some do this. Many people get lost. If you are missing long enough the nurse will go looking for you, again leaving her area unattended. If a medication is needed you will wait one to two hours for delivery.

DR. PATTILLO:

Thank you, Traci. Are there three LPNs for these physicians? Do you have any RNs? Physicians? Do you have any RNs?

MS. PAVETTI:

Two RNs, one LPN that is the minimum. That's it.

DR. PATTILLO:

Thank you.

Mr. Volk:

Good morning. My name is Herb Volk. I work at Togus VA in Atlanta. I'm a nursing assistants on the surgical floor there. My concerns are that as VNAs we have no promotion incentive to speak of. We can go from a GS 4 to a GS 5. As mentioned before, we don't get any Saturday differently. We have no where to look forward to and what is happening here is we as VA are spending a lot money training CNAs. What we're doing is making them marketable on the outside. And consequently our CNAS get trained by VA and go outside where there is promotion incentives. I believe we need to look at this and try and keep our qualified CNAs.

DR. PATTILLO:

Do you have suggestions?

MR. VOLK:

We need to increase our incentives. We need to give more opportunity for promotions instead of limiting our CNAs to a GS 5 to make the opportunity to go higher in the GS ratings. The CNAs are promoted to a GS 5 regardless of abilities and they can go no further. Outside of the state of Maine CNAs can go on for critical care techs until they get their license as an LPN or RN. We can't do that in VA. We are stuck at GS 5 level and our only promotions are the step increases. Saturday differently. We work Saturdays because we're required to work Saturdays as all the nursing staff is. And LPNs and RNs get the Saturday differential we don't. And it is discouraging to our nursing assistants and they have more opportunities on the outside of the VA.

DR. PATTILLO:

Thank you, Herbert. We have time for one more. Ken O'Leary.

MR. O'LEARY:

My name is Ken O'Leary. I'm a nurse of 31 years federal service. I'm also at Durham VA, 31 years federal service. I'm also a veteran. I would like the address the committee about the concerns with staffing levels that are based an acute level that is outdated, outmoded and does not justify the age and acuity of our patients. And I also would like to address the promotion system. We have nurses that are frozen from 8 to 15 years in Grade 2 with no ability to advance. We have nurses that have been brought in as AD nurses and placed in management and will make Nurse III within a year. This is a cold slap in the face of us that are supposed to be the backbone in holding the VA together. Also on education opportunities they seem to forget that there are more of us on day shift. The opportunities are only open for day people from ten or three. So we would like to see more education opportunities open for other tours.

DR. PATTILLO:

Okay. Thank you, Ken. Why don't we take a short recess for 30 minutes. Now the bathrooms are down there and it looks like there is an overflow and we will take a break. Let's come back here at 10:15(Whereupon, a short recess was taken.)

* * *

DR. PATTILLO:

Let's begin. Our next speaker is Roxanne Fulcher, American Association of Community Colleges. Roxanne.

MS. FULCHER:

Good morning. I am Roxanne Fulcher with the American Association with the American Association of Community Colleges. I'm the director of health policy or health professions policy with the association. And today I've asked Andrea Mengel with Philadelphia Community College to testify on behalf of the ACC.

MS. MENGEL:

Thank you for the opportunity to talk with you. As a lifelong nursing educator I'm very disappointed in the hiring and promotion policy instituted nationwide by the department of veterans affairs. The nursing qualifications standard discourages associate de greed nurses from working in the veterans health administration because they cannot advance after two or three years of working as a registered nurse. With numerous choices of workplace opportunities, why would an associate de greed graduate choose to work in the veterans health administration when the hiring and promotion policy holds them back. Community College of Philadelphia has graduated over 300 registered nurses in the past four years. Not one of these registered nurses chose a position with the veterans health administration. The veterans health administration is losing an invaluable opportunity to recruit nurses from Community College of Philadelphia and other associate de greed programs. These nurses are excellent professional nurses who wish to provide patient care as well as to advance in their careers. Community College of Philadelphia supports higher education and continuing education opportunities for all nurses in an inclusive model that promotes articulation of the nursing student at all levels from nursing assistant to practical nurse to associate degree nurse to baccalaureate and master's degree graduate level nurse. We know that the majority of nursing graduates are an associate degree. In addition we know that the examination pass rates for RNs with associate degrees in nursing is equal to the pass rate for RNs with a baccalaureate degree in nursing. We know that the number of minority students receiving associate degrees in nurse is increasing. We know that communities colleges educate the majority of the nurses in rural settings. We know that RNs educated by Community colleges are more likely to stay in their communities to practice nursing. We know that associate degree RNs represent more than one-quarter of the students enrolled in baccalaureate schools of nursing. We know that community colleges offer cost effective and accessible nursing education. To continue to provide high quality nursing care for their clients, I recommended that the veterans health administration adopt the following and hiring promotion strategies: Employ new associate degree graduates at the same level as baccalaureate nurses, and provide promotion opportunities for all registered nurses based on performance and continuing education. Thank you.

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MR. WILLIAMS:

Good morning. And I would like to thank the members of the panel for being here and I'm would like to thank everyone that works for the VA that has taken time out their day to come to this very important meeting today. There is people that have come from a very long distance and I am really proud to see such a big group of people here today. Ladies and gentlemen, today you are going to hear testimony on a variety of problems concerning nursing personnel in the VA system. In order to understand this complex problem I feel that I must give you some background into the ongoing situation. My neighbor is a retired hospital and about two summers ago we were sitting on his front porch and I was complaining as usual about problems and over a beer he gave me quite a financial lesson on the way things go within a hospital. He told me that as an administrator the easiest way to manipulate the budget is to play with the nursing budget. He said first of all there are certain things that have to be paid: utilities, interest on bonds, equipment. They are very important because if they are not paid the hospital gets shutdown. But he said what he can

play with is the nursing salary. He said if you have 200 nurses and you want to give them a$2 raise that amounts to close to over$800,000 a year and if he wants to manipulate that budget he can. He can give the nurses a $1 raise. So it is very, very easy for a hospital administrator to manipulate the budget. In the VA system the nurse locality pay, the nursing pay act of 1990 was a very good conceived system. The only problem is the members of Congress forget to put a checking and balance system into the situation, just like the way our government is set up. What this created is each hospital administrator at a facility has the ability to do whatever he pleases with the budget. He can give you a raise. Usually the people who are most affected are the nursing personnel, and that goes from nursing assistants all the way up to CRNAs, certified registered nurse anesthetists which I am. The VA health care system I feel currently lacks the financial and professional incentive to attract and retain qualified certified registered nurse anesthetists. The major problem for nurse anesthetists at our facility involves the nurse locality pay process. The community hospitals in our local labor market have been forced to increase their salaries up to$52 an hour to compete for a shrinking group of graduate anesthetists. The competition is fierce. And the problem will continue to get worse. The salaries scheduled for our facility has a starting rate of $31.83 an hour for a new graduate, with a maximum rate of $51.90 per hour. Our starting rate is 63 percent behind other facilities. 63 percent behind other facilities in our local labor market. How could this happen if the human resource department conducted yearly salary surveys? There are many answers to our question. The survey process at our facility has been conducted with the shroud of secrecy. Since the locality pay survey began in 1991 CRNAs at our facility have participated in the process twice. The check and balance system was eliminated so the HR department could manipulate the data. In January we our nurse executive with our concerns. We submitted a letter to have included this letter hopefully to be read today during testimony. We also have submitted at the time documentation of starting salaries for our local labor market from a variety of source. These include newspapers ads, professional journal ads, and information from a Web site called gaswork.com, letters from local hospitals and a pay stub from a local facility. We were told an independent agency would conduct the survey this year and the data would be presented in March. We're still waiting for the results and hope to close the gap with our local I would like to read the letter that competitor. We wrote to our nurse executive and hopefully it went out to the medical director of the hospital but we'll never know that. The nurse pay act of 1990 was designed to provide competitive pay scales based upon starting salaries from non-VA health care establishments. This system was created to a attract the best and brightest nurses into the VA health care system. The national nursing shortage plus the increased demand for certified registered anesthetists has also impacted the VA health care system. The association of veteran nurse anesthetists has indicated that 42 of a 116 VAs currently doing surgery are reporting CRNA vacancies. Many with multiple positions unfilled. The average age of a CRNA in the VA health care system is 50 years and half of this group have indicated that they will retire within the next five years. We have included a copy of the VA work force planning group, a call to action, the VA's response to the national nursing shortage. I don't know if the members have had the opportunity to review this but it is very good. It was started in August of2000. It was completed in November of 2001, and we still haven't seen any action. This is a excellent study which has indicated that the department of veterans affairs needs to take bold and un president action to position itself as an effective competitor for the scarce nursing

shortages. The planning group need to de mystify the current hiring and identified pay authorities as the first step in addressing the nursing work force shortage. The lack of flexibility to compete effectively in a rapid changing job market will likely leave the VA unprepared to provide quality care to the nations veterans. We have experienced many problems with the locality pay service at the Wilkes Barre VA medical Center. Lack of CRNA participation on the survey team, violation of anti trust laws and insufficient data have created major problems with the CRNA pay schedules. Anyone who has taken a course in statistics knows that a survey is only good it is data obtained. The survey of one or two hospitals is inappropriate. The results are flawed due to insufficient data. We have included a comparison of the VA pay scales compared with Geisinger Medical Center, which is a large competitor in our area from 1990 to2002, which indicates major differences. The latest salary adjustment at Geisinger has increased the rate for a knew graduate to $52 an hour. The same salary for a graduate at the VA is $31.83. The VA would have to increase there to currently match the starting salary of Geisinger Medical Center. More disturbing is the fact that a new graduate is paid more than the highest rate at VA. How can the VA be competitive? We can provide newspaper ads, journal ads, private mailings, information from the Web site, gasworks.com that shows other hospitals with similar starting salaries. It is difficult to obtain accurate information when those who must collect review and approve the data do not immediately feel the urgency and priority of most recruitment. A starting salary from an institution that hasn't hired a CRNA within the past year must be excluded because of the rapid changes in the volatile job market. The human resource department at this facility has done a deplorable job conducting the locality survey. We can only hope that the outside agency currently conducting the survey will do a better job obtaining current starting salaries from non-VA facilities. In closing, sir, and, ma'am, the nursing work force planning group call to action the VA's response to the nursing shortage has already conducted research on these issues and prepared an excellent of recommendations. You don't need an MBA degree to solve this problem. Supply and demand for any product will dictate price. Nursing anesthetists are in short supply and the demand for their services are increasing. The competition between hospitals has sent salaries spiraling upwards. Benefit packages, sign on bonus, educational allowances, tuition repayment plans are being offered making the VA health care system less and less attractive for the shrinking group of qualified applicants. The salaries for CRNA aren't a government secret. They are published openly in newspapers, journals, and employment agencies. Thank you.

DR. PATTILLO:

I have a question. In terms of your letter here, did you get nothing? You have received nothing?

MR. WILLIAMS:

I received nothing

DR. PATTILLO: Okay.

Do you have any questions?

MR. DANDRIDGE:

In YOUR testimony, you speak to some of the, I guess, the opportunities, experiences that demonstrate local practices that tend to be manipulative in regards to a fair an unbiased effort to benchmark against the local market. And certainly I think to the extent that you have 161, whatever it is the number is, a facility that potential certainly does exist. Do you have a recommendation that you would make to this commission as to how You would propose resolving that particular concern or issue?

MR. WILLIAMS:

I think the Nurse Pay Act of 1991 was designed very, very well. The only problem is the facility director has all the power to do whatever he chooses. And because nursing budget in the hospital is such a large budget I think it is very, very tempting to manipulate the data. I think that if anything gets changed I think Congress should put something -- if they don't change the Nurse Pay Act they should put some method in there that there is a higher authority that local facilities can go to and complain and ask for an investigation. Personally myself I don't see a Future in the VA health care system. I think the administration or they are two worried about meeting budget ends, which is a concern of every hospital, but if you can't attract and retain qualified people your system is going to close. I mean, if you ever gone to a hospital at night or on a weekend with a sick loved one and look around and see what you see. You don't see administrators; you don't see human resource people. You see Doctors and nurses if the VA can’t afford to hire them the system is going close.

MR. DANDRIDGE:

You indicate that Nurse Pay Act in itself is workable

MR. WILLIAMS:

I think it was an excellent system, except that members Congress, they left all the power in the head of the hospital director, which is wrong and it has been manipulated, sir.

MR. DANDRIDGE:

Is there anything in your mind that would preclude doing those surveys nationally, and then looking at the local?

MR. WILLIAMS:

Sir, I have so much information here. I don't know if there is any other nurse anesthetist. I'm sure nurses get the same information. This is a packet of job ads just from January of this year. Local Pennsylvania ads and national ads. The demand for people is so great; the Pennsylvania legislators are very concerned in Pennsylvania. The amount of people going into nursing continues to drop and drop. And when we need nursing care there is not going to be anyone there to take care of us. I mean I have two children. They are both in college now. And whenever their friends would come over I would say: What career are you going to take? And there is people going into medicine, law. Not one out of two classes of over a 150 people, not one person chose nursing.

MR. DANDRIDGE:

Okay.

MR. WILLIAMS:

Thank you

DR. PATTILLO:

Jan Rogers:

MS. ROGERS:

I am Jan Rogers and a nurse practitioner in Fayetteville, North Carolina. 'm relatively new to the federal work force. And little did I know when I joked about needing an Act of Congress to implement any changes would I be addressing you today. Today I would like to address the following issues: pay disparity between nurse practitioners and physician assistants, grade levels, qualification standards, nurse professional standard boards and recruitment and retention of a quality work force. At the VA nurse practitioners are required to have a master's of science degree in nursing. Physicians assistants are only required to Bachelor of Science degree. At the Taylor VA on average PAs make more than nurse practitioners. One year ago it was noted that the average PA annual salary was a little over $75,000. Well, the average nurse practitioner annual salary was a little over $66,000. Both have the same job descriptions, requiring the same number of years of experience. One factor leading to this pay disparity is the fact that nurse practitioners and PAs are on different pay schedules. For example, PAs are on the GS system and nurse practitioners are on the locality schedule. PAs, to my understanding enter as a GS 12 and this is equivalent to the Level 3 of the nurse practitioner. This leads to the next issue of grade levels. Within nursing there are five grade levels. Each level represents a level of complexity. To my understanding only levels from 1 through 3 are available to most nurses. Level 4 and 5 are reserved for nurse management. Basically Level 1 reflects the new graduate practice. Level 2 reflects the nurse with intermediate experience and Level 3 reflect the nurse performing complex nurse care. Despite this practitioners do no necessarily enter fact the system at Level 3. I myself, an example this. Despite the fact that I have a dual Master’s degree from Duke University as an adult nurse practitioner, an oncology HIV nurse practitioner I was hired as a Level 2. Nurses entering the federal system for the first time are not familiar with this system and that was truly my case. So I didn't know to negotiate this point of my hiring package. In my facility nurse practitioners and primary care have a panel size of 850 patients. We're responsible for the veteran’s total primary health care needs. Surely, a nurse practitioner with a Master’s degree with this level responsibility and performing complex care should enter as a Level 3 Recommendations: nurse Practitioners should receive equal pay for equal work. Based on our education level and complexity of scope of practice, nurse practitioners should enter the system at minimum of Level 3 since it is equivalent to the entry level of the PAOGS 12. Nurse practitioners should also have the opportunity to advance to Level 4 without entering the management arena. Another area of concern are the qualifications standards. The qualifications standards are not well understood. While the intent of the

standards are admirable, better, complex, wordy, subjective and do not reflect the clinical practice of a nurse practitioner. The standards have attempted to make pigeon hold all nurses into one practice. Nurses are familiar with the saying: a nurse is a nurse is a nurse. While nurse practitioners are nurses but we're providers. We make independent treatment decisions. We prescribe medications orders and interpret labs and diagnosis stick tests. No where do the standards reflect this level of care. Compound this with the fact that Level 3 staff nurses are involved in the boarding and promotion of the nurse practitioner also learns to deal with a problem. Staff nurses unfortunately are not prepared nor qualified to measure nurse practitioner performance. My recommendation would be the standards should reflect the practice, the nurse practitioner role as a healthcare provider. Only nurse practitioners should be involved in the boarding and promotion process of the nurse practitioner. We should have our own separate board. Those applying the standards are members of the Nurse Professional Standards Board. Again while the intent of the standards are admirable, the board attempting to apply the standards is poorly prepared for such a lofty task. There is no formal training for the board members. New members learn from the contents of the current membership regardless if their methods are correct or not. I have served on that board and it was a very frustrating experience. The chairperson would literally read the evaluations and members would sit and listen and hear if they heard the correct content. Members were focused on small details such as a particular word. If the information was not in the correct spot it was discounted. Within a seven-month period I witnessed only two staff RNs achieve promotion. In a two-year period only one nurse practitioner has been promoted to a Level 3. The board should training from an outside source. A reviewer receive yearly should also perform independent audits of the board actions to identify problem areas in potential improvement. Finally, the VA system is a challenging system to work with and for this reason it's difficult the attract and retain a quality working force. The system lacks some of the basic incentives offered within the private sector. For example, nurse practitioners do not have budgeted funds for required continuing education. An average conference cost well over a $1,000. Yet we have no budgeted funds. The money happens to be available we might get the registration cost covered. If not then we must incur the cost of the conference. The private sector standard is a$1,000 per fiscal year with 40 hours of education leave. The private sector also offers a standard $500 for dues, books and subscription. Once a nurse practitioner reaches a salary cap we should receive some incentive to remain within the system. This could include additional leave time, contribution awards or additional funds for the continuing education. The VA does have an attractive program called the debt reduction program. This program will forgive school loans in return for service. For example, over a five-year period they may pay up to $44,000 on a school loan. Unfortunately, although the program has been approved the program has not been implemented. It has been almost a year since I submitted my approved applications but no funds have been disbursed yet. Recommendation would be to offer nurse practitioners budgeted continuing education funds along with additional incentives for license renewal professional dues, book and of course implement the debt reduction program.

DR. PATTILLO:

Well, I guess you don't have time to do any school affiliation to serve as adjunct faculty for the university, right.

MS. ROGERS:

Because you are seeing850 patients and being in charge of all of them, yes.

DR. PATTILLO:

So you answered my question in that regard. But the other thing is in terms of do people know the difference between the nurse practitioners practice and the PA practice? Why one would go with one versus the other and how you get more bangs for your buck perhaps this way versus that way?

MS. ROGERS:

This is true also in the private sector. Physician assistants start with the word "physician" and they see the physician assistant as a physician. And then a nurse practitioner as a nurse. A lot of times I have been asked, Well, when are you going to become a PA? The public is not well educated what the difference is as far as nurse practitioners and PAs. And I am really amazed at the different -- you know, a physician assistants could be working in FedEx and in two years be a physician assistant. And they don't understand nurse practitioners have nursing backgrounds and usually for my program you are required five years of experience before acceptance. So there is –

DR. PATTILLO:

Is your emphasis on patient education and family considerations Versus the medical models?

MS. ROGERS:

Yes

DR. PATTILLO:

Just wanted to throw. That one in, Thank you very much.

MR. DANDRIDGE:

I would like to compliment all of those that testified through their testimony and I really hate this red card. I tell you. But, I also want to compliment you. I think that your testimony was very succinct. You had very concise recommendations and obviously well thought through and I do appreciate it.

MS. ROGERS:

Thank you.

DR. PATTILLO:

As the other testimonies. Okay, Maureen Levesque.

MS. LEVESQUE:

I will introduce myself. My name is Maureen Levesque. I am from VA Boston health care system where I have worked for the last 10-1/2 years. I'm currently the clinical resource nurse for both medicine and surgery at the West Roxbury and Jamaica Plain campuses. I have been a nurse for over 20 years and have worked in many different fields of nursing including the operating room, IV therapy and home care. I have always been very active in my profession. I have been a member of the Massachusetts Nursing Association, the Nursing Society, and I have published in AJM. I'm on a variety of committees at the VA including recruit and retention, policy and procedure, practice and advisory, and I have been the elected chairperson or the appointed chairperson of nursing grand rounds. I'm a member of NOVA and currently serving a vice president of our local Chapter 226. I am also a member of the MAGE, local 187 AND has served as a union steward for two years. I want to thank the members of the National Commission for inviting me the come to Philadelphia to give this testimony. I am honored to have been asked. I will begin my testimony by saying I love being a nurse, and I'm proud to work for our veterans. I have a husband that is a combat veteran from Vietnam. My father was a World War II disabled veteran. And my father is a World War II veteran. All three
received their services from the VA. When the survey was sent, I answered the six questions and sent in my response. Today I will address the questions that I am most passionate about Question 6 which we will hear all. Throughout this testimony deals with our pay, and regarding the locality pay. This needs improving. The VA as everyone here knows is way behind our local hospitals in pay. I know our package looks good and it is very attractive to our new grads. We offer a great 401K plans, free parking, and union allowance, and a fairly comparable starting salary for the new nurse, but it ends there. VA nurses do not advance as fast as the local hospitals nor with the high salaries. And many of us are stuck in a position. Myself, I'm working towards retirement. I will not go to the local hospital. Also, most of our local hospitals at least in the Boston area offer health insurance plans with larger employer contributions. That's an issue for another testimony. Another part of Question 6 is in regards to the qualification standards and grade level. This is a system that needs a tremendous amount of change. To start with, I believe that all nursing boards should have a union representation even if the union does not act as a voting member to the boards. As a union steward I sat on the nursing board. I have seen where having a union member present is valuable and often time’s discrepancies among the boards have been picked up by the union member. It also lets the union see how the board functions and enables them to educate our employees on the process of proficiency writing. Along with this education we also encourage our employees not to leave the VA because they were not promoted in a timely manner. The next area I would like to address is Question 4. How can the VA better support education and training? The VA is offering to pay off student loans for new nurses yet it seems to be a chore to get funding for our seasoned nurse that were returning to school. There are many programs that offer funding but you must complete the program first to get the funding or the paperwork such as an EEI is very tedious to fill out. And it becomes very frustrating trying to find somebody to help you with that paperwork. A lot of the programs that offer money require that you work full-time as well as attend school. Isn't there a way the VA can give the nurse time off for clinical part of school in exchange for time paid back to the VA when the school is completed? I was very fortunate when I went for under grad. My husband work for Commonwealth of Massachusetts. As

long I went to a State College I only need too show the state a voucher and I would receive tuition exemption or a partial exemption. If I worked for the Commonwealth with 20 hours a week I would be fully exempt from tuition at a state school. Surely the VA can come up with program that is user friendly and would have a more nurses returning to school and thus having the VA retain more of its nurses. On the education and training of staff, the VA requires that all full-time staff have 40 hours of education per year. Yet there are many stumbling blocks that prevent the nurses in completing this Today our patients are sicker, requiring a. lost more bedside care, and with staff shortages getting medications out, notes written, doctors calls and patients made comfortable, it does not leave much time for the mandated programs. If nurses do not meet the required mandate, they spoken to by the education liaison as well as the nurse managers. One of the ideas I have is to schedule staff for an eight-hour education day every other month. The goals for 40 hours would be complete within five days. This also enables the nurse to be off the unit and attend classes with other nurses within the system. The interaction with other nurses would help share ideas on patient care as well as ways to better utilize time in the delivery of that care. The VA Boston health care system has three campuses as well as many outpatient clinics. If we had education programs alternating between the campuses it not only lets us meets other VA nurses, it will let us see the many different roles that the VA has for its nurses and it lets the nurses see the different services that are provided at each one of the campuses. At the VA Boston campus one is acute care, one is long-term care and one holds clinic in small surgical cases. I believe we all know there is a nursing shortage and it is not going to go away very soon. The VA needs to be the leader in recruiting and retaining nurses. This begins with nurses being paid comparable salaries to local hospitals, changing the way the nursing board functions and having union members present at all boards and having tuition programs that are easier to obtain and work within the mandate education hours to accommodate all staff making it an enjoyable task and not a chore. I want to again thank you for inviting me to me to be here today to give this testimony. Again I'm Maureen Levesque from the VA Boston health care system, and I think thank you.

DR. PATTILLO:

Maureen, how much do you think is the local problem versus a systemic problem in terms of the nurse board never changes its members?

MS. LEVESQUE:

I think I do not feel that it is a local problem. I think it is a national problem.

MS. PATTTILO:

More systemic situation.

MS. LEVESQUE:

Yes, I do.

DR. PATTILLO:

Thank you very much. We have some time for some open mike testimony. So I would like to ask Rick Martinto come up and give his three minutes.

MR. MARTIN:

My name is Rick Martin. I am a Nurse II with a BS degree and four years experience at the Hampton VA medical center. I'm also a 20-year Navy veteran. My preceptor when I was oriented in ICU was a Nurse II with over 20 years of experience. Also one my co-workers, a Nurse II with an AD degree and 10 years experience. Both are outstanding nurses and I learn from them on a daily basis. However we will never be advanced to Nurse III because of the requirement to have an MSN degree. Nursing experience within the VA system is not rewarded. In fact it is punished because of an educational requirement. Yet, there is no better education than experience. The nurse professional standards board is a quasi peer review process. They are not independent. The chief nurse and director had the final say of person is to be advanced, whether an individual meets the requirements or not. The boards need oversight. It needs to be reliable and consistent. We are the ones being evaluated and we should have a say in the process. Many nurse managers often times do not even submit annual reviews in a timely manner and there seems to be an inordinate amount that are lost and have to be redone. Over the last four years of my experience it routinely takes six to eight months from the time the review is signed by a nurse until he or she is either advanced to the next level or they are told they do not meet the requirements. In fact I have not met a nurse net that has been advanced on time. Some of them have been at the VA for almost 30 years. If the nurse is advanced and the person's annual review date is arbitrarily changed to a later date when the board actually acted on the review, there is a six to eight months gap. This six to eight months lag in the administrative process has cost the nurse six to eight months in pay at the next level and the change an review date has impacted advancement for the rest of his or her career at the VA. It is only as result of a official grievance and arbitration through an independent mutually agreed upon third party that the administration may change the review date back to the original date and compute back pay for the six to eight months' difference. However, this is not guaranteed. This process has gone on long and it has affected so many nurses that one begins to wonder if this is a planned cost is balancing the budget on the backs of the nurses. So, recommendation: Nurse managers must submit reviews on time and held accountable for those that are not. Mandates that at each board meeting there must be an independent neutral agreed upon third party present. Mandate the maximum time frame in which the board must act upon a review. Mandate that a person's review date cannot be arbitrarily changed, and automatically compute back pay for those advancements that go beyond the maximum time frame in which the review must be acted Thank you.

MR.DANDRIDGE:

Great recommendations. I discern from your comments that management is not responsive in timely reviews. Now when that occurs, your comment indicates that the supervising manager then changes the review date

MR. MARTIN:

That's correct.

MR. DANDRIDGE:

To that new date

MR. DANDRIDGE:

Is it your perception that is a national or common practice?

MR. MARTIN:

Well, I can't speak to that. I do know that it is very common at the VA I work at. I mean in fact, I don't know that -- like I said, I don't know of anyone that has actually had a review on time, and everyone I've spoke to about this, because this personally happened to me, no one has had to wait less than six months to get their advancement and they were just out the money.

MR. DANDRIDGE:

Thank you.

DR. PATTILLO:

Thank you very much. Let's hear from Mary Zemaitis.

DR. ZEMAITIS:

I'm Mary Lou Zemaitis from the VA Pittsburgh Healthcare System. I'm a Ph.D. prepared nurse with 41 years of nursing practice, and I have had 10 years at the wonderful VA Healthcare System in Pittsburgh. In 2000 the National Center for Health Workforce Analysis reported that we had 1.89 million registered nurses in the work force, six percent fewer than were needed. The National Center predicts that by the year 2020 we'll have a deficits of1.5 million. In 2002 the American Association of Colleges of Nursing conducted a survey of363 schools of nursing reporting an eight percent drop in nursing school enrollments over the 2001 rate. So as I see it we have double trouble. A decrease number of our RNs in the work force, and a decreasing number of nurse trainees in the pipeline who will replace those of us who are due to retire in the very near future. Challenge No. 1. How do we attract a quality nurse work force? I had to have surgery just a month ago and as I was preparing to undergo anesthesia I had two nurses ask me about job opportunities in the VA. And the anesthesiologist also asked me about them and all three of them requested my business card so they could do further contact and follow up. So I think the work is out that we have a remarkable Healthcare System but we need to do more than just rest on the laurels of what we know we have done well. We need to start now to plant the seed early and at Pittsburgh we are initiating our first ever Take Your Child to Work Day next Wednesday. I can't tell you what the outcomes will be but I can tell you that we're bringing children as young as the age of 10 in for a full day of activities at all three campuses to explore what it would be like to have a career in the health field. We also have at Pittsburgh a high school based nurse aids certification-training program for selected high school students who show talent and interest.

These high school trainees come in to our VA Pittsburgh learn how to be a nursing assistants, receive certification when they graduate, they have a marketable talent and skill and we at the VA Pittsburgh have first choice on those new graduates. What else do we need to do to attract them? Well, we need to create job shadowing experiences for elementary and high school students and I don't want the hear that we only allow 14 years older and up to be volunteers. We're not talking about people doing volunteer work. We're talking about interesting children in a future health care career, hopefully nursing. We need to do more to market our scholarship programs. I have heard nurses this morning say that we have a program but it is not doing enough. But I am scratching my head wondering why isn't it enough. At Pittsburgh we have almost a 180 nurses getting EISP or NEEI funds. Last summer we submitted 28 names for education debt reduction. All 28 were approved for funding. The first payment on that funding will come when they have served their first year as a VA health care worker this July 1. So we need to also develop more preceptor programs and I'm not talking about a one or a two-week program for ADN or BSN nurse. We need a full 15-week preceptor ship program. So these nurse trainees can find out how great it really is to work at VA. So that they can feel a part of our system and become engaged with us because before they take the steps away from their basic academic program. The second challenge is how do we retain a quality working force. I will save that for another day. Thank you.

DR. PATTILLO:

But you can submit that information to us as well. So we really do appreciate that.

DR. ZEMAITIS:

I will do that.

DR. PATTILLO:

What your job? Are you nurse executive?

DR. ZEMAITIS:

I am the director of education and I have responsibilities for all employee training, professional and non-professional, house staff, residents, nurses, et cetera.

DR. PATTILLO:

Do you conduct any nursing research?

THE WITNESS:

I put in 60-hour workweeks. Now, I do conduct research on the outcome of our programs, our education a training programs, and we keep a record of the statistics of success of the nurses and the other trainees.

DR. PATTILLO:

You encourage your staff to help collect data in terms of their -

DR. ZEMAITIS:

My critical care staff do critical care outcome studies. My med/surg staff and long-term staff do as well.

DR. PATTILLO:

And that is mentioned in the performance reports; right, all their experience?

DR. ZEMAITIS:

I consider it when I hear the staff presenting testimony saying They don't know when they last received a performance award, I want to cringe. I consider myself a failed manager if I can't provide my staff who have done exceptional work with some sort of a reward a bonus for the work.

DR. PATTILLO:

Okay. One more. Sandra Lucas

MS. LUCAS:

Good morning. My name. is Sandra Lucas. And I am a LPN working in the primary care department at the VA Togas and I'm very proud to have served and cared for our veterans within past 20 years. I would like to state the concerns of promotion and advancement of LPNs within the VA. We have many exceptional and skillful LPNs that have been there for several years, and throughout the past years the complexity of our role has changed tremendously, and our responsibilities are amazing where our pay scales has not changed to reflect the added responsibilities we have assumed. And some of those responsibilities are IV therapy, educational clinics and leadership roles. The top grade for LPN is GS 6, and many of the LPNs are at the top of their grade, even though they have several years of service left with no incentive of receiving a pay raise. I urge the commission to address the pay inequities so we are able to properly care for our Veterans. I understand that the VA will be allowing LPNL promotion to GS 7. I find that this is too little and too late. I find this unacceptable and I hope the commission will further review our pay scale. Thank you.

DR. PATTILLO:

Thank you, Sandra, very much. Margaret Duryea.

MS. DURYEA:

My name is Margaret Duryea. I am a registered staff nurse working in a staff position at Northport VA currently in the primary care clinic and oncology clinic. I have worked at Northport for 20 years and I have been on inpatient and I have rotated shifts. And I would like to say that rotating shifts impairs the recruitment and retention of VA nurses. The pattern of rotation is irregular, in that our time or certified time is posted maybe two three or four weeks in advance, and one might work days, evenings or nights within that time period. This does disrupt your home

life. It disrupts your opportunities for education. It disrupts childcare needs. It disrupts your physical being. It interrupts your circadian rhythm. It increases physical and mental stresses on the job, which then has consequences on your work performance. The consequences to the employer is that there is a less deficient worker on the job. This means increased errors, medication errors, thinking errors, increase time loss to injuries due to physical fatigue, more sick calls. When a person is not prepared to work an off tour and suddenly finds himself scheduled to do so he may decide just not to come in and therefore that position has to be covered by unplanned overtime. It also disrupts the work cohort and the moral of the units. Some people feel I didn't sign up to work nights and now I have to work nights. You know, one or two or three days a week and then come in on days the next time around. It makes for an unhappy work force. What are some alternatives? Why is it not possible to hire for shift? Hospitals in the communities do this. When they publicize their positions, they say, we have a nurse opening for evenings. We have a nurse opening for nights. Somebody who wants to say work evening or wants to work nights applies for the job. Why can't we do that? There are other alternatives one might look at, having a line schedule that is published for the whole year, so that a person knows I'm always going to be off on the a certain day. I'm always going to be working evenings or nights if I have to at a certain interval. So I can plan my life. I can line up my baby sitters. I can take a course to improve myself if I want to. I know whose graduation I can go to and who’s wedding I can go to. Sometimes these lines schedules are matched in pairs so that one person backs up another person. What about the Unscheduled absences, sudden sick leaves, home emergency that take a person out of work. How are those to be covered? We have had good use of per diems at Northport VA, especially inviting retired personnel to come back on a per diem basis. Some of these people are willing to work off tours. Some people are just night people and they like to do it. I don't understand why but they do. And some people are happy to work evenings so they can be home in the daytime with their families. Opportunities need to be discussed with the staff.

DR. PATTILLO:

Thank you very much. We will go back to our schedule now. It is Dr. Gloria Donnelly, AACN, Drexel University.

DR. DONNELLY:

My name is Dr. Gloria Donnelly. I'm the dean of the College of Nursing and Health Professionals at Drexel University, and I'm representing the American Association of Colleges of Nursing today. The veteran health administration is a recognized leader in adopting Best practices and setting the standards for quality health care in the United States. The administration's commitment to improving patient care and reducing medical errors serves as a model for other health care providers to follow. As the nation's largest integrated Healthcare System with almost 36,000 registered nurses, the VHA is the nation's single largest employer of RNs and as such plays a lead role in setting the professional standards for nursing practice. The VA's commitment to providing the best possible care to our nation's veterans extends to preparing a well-educated nursing work force. The VHA employs nurses in roles consistent with the educational preparation and provides them with the education necessary to develop new clinical skills and move forward their nursing careers. The VA supports for the

Bachelor of Science in nursing for positions held beyond the entry level is consistent with other progressive health care facilities. They place a high value on learning and are also recognized for their nursing excellence. Nurse executives, federal agencies and minority nurse advocacy groups all recognize the unique value that baccalaureate prepared nurses bring to the practice setting. In this same vein, the VHA's nurse's qualifications standards create a model career ladder program for the profession that is essential to maintaining patient safety and diversifying the nurse work force. The American Association of College Nursing is the national voice for baccalaureate and graduate nursing education, representing more than 570 senior colleges and universities that educate over 150,000 students each year and employ 9,300 nursing faculty. AAC and member schools work in collaboration with the VHA to provide the necessary education to help develop the VHA nursing work force. VHA employees are attending 300 different educational institutions and almost 400 hundred locations throughout the United States. Many nursing education programs are offered on site at VHA facilities and many of these facilities provide clinical placement opportunities essential to educating new nurses and assisting in the transition from academia to the clinical setting. The VA provides significant financial support for academic achievement through the national nursing education initiative. This program ensures that VHA work force can meet the challenges of an intense complex, technological and changing work environment. The NNEI program awards to tuition support to nurses to obtain baccalaureate or postgraduates degrees in training. The average awardees receive$11,000 in tuition assistance. In support of this effort the VA has partnered with schools of nursing to provide educational opportunities to its employees on site by the Internet and through other alternative arrangements. The latest NNEI program statistics indicate that there are 2,702 total participants with 61 percent enrolled in accalaureate programs. A total of 454 participants have already completed a BSN degree. Additionally, the platform supports and generates the potential nurse faculty with 995 masters, and 55 doctoral program enrollees. Information collected from a 2002 nursing personnel exit survey indicates strong support for the NEEI and the nursing qualifications standards. Among the 2,428 nurses who left the VHA system primarily through retirement, 64 percent said that the VSA and the VHA standards will either attract higher quality candidates or enhance the nursing profession. And 86 percent acknowledge the VA support to nurses to pursue their educational goals. None of the departing nurses listed the change in educational requirements as a reason for leaving. In addition, the VHA's nursing turn over rate in 2000 was 9.5 percent, substantially less than the national average of 15 percent. And I would add on more personal note I'm currently working with some hospital systems whose turn over rates are hovering at 40 percent. So, it seems to be the VA is doing pretty well. The VHA employs nurses in roles congruent with their educational preparation and the VA has created a career latter program for its nursing work force based on different educational preparation. Beginning in 2005 the administration will require an AD or diploma for Nurse I positions, a BSN degree for Nurse II and a master of science in nursing degree for Nurse III. Similar practice models have been implemented in acute care operating rooms, inpatient settings, rural community nursing centers and so on and so forth. The VA has demonstrated a strong commitment to increasing diversity among its RNs and other health professionals. Nurse leaders recognize the connection between a culturally diverse work force and the ability to employ quality patient care. The VA has developed comprehensive strategies to ensure that enhancing diversity remains a top priority. AACA fully supports the VHA's commitment to expand opportunities for nurses to obtain baccalaureate and

advanced degrees in nursing through the NNEI initiative. In addition the VHA nurse qualifications standards establishes system wide framework that recognizes educational preparation and awards performance, in advancing through the nursing career ladder. On a more personal note, I'm an educator. I'm dean of a college of nursing. We all know that the American dream has always been education. Knowledge is doubling every five years. And we owe it to our patients to have a highly educated nurse work force, so they and their families will receive the highest quality care. Thank you.

DR. PATTILLO:

Thank you very much. Okay. The next speaker is Henry Holden, Baltimore.

MR. HOLDEN:

Good morning. My name is Henry Holden. I'm an RN and a veteran. I currently work at the Baltimore VA Medical Center where I have practiced for the past 17 years. I received this questionnaire. I filled it out and I was invited here at your request. I appreciate the opportunity to speak. The Question No. 1: To what extent do nurses facility controls the decisions directly related to nursing practices delivery of care? To the extent that the nursing administration within each clinical center at my VA or service lines as a some of them are called, there is no departments of nursing and therefore nursing leadership is, in my opinion, compartmentalized. The nurses are either asked or assigned to take part QI nurse practice council, et cetera in addition to other committees, where they give the appearance of some control and decision making. Perhaps they do have some input in decisions but I'm not knowledgeable enough on that process to comment. Each department I believe has a nurse executive as the ultimate authority and nursing policy making for that particular service center. These nursing executives apparently answer to their service line director or clinical service director who in some cases may be an M.D. There is also chief nurse executive, although I'm not sure exactly what her responsibilities are. In my department, for example, the services line director is a psychologist. Her decisions often impact on nursing and she has no nursing experience. The nurse executive seems to take his clue from her and, in the opinion of many, has not supported the nursing staff issues because of his relationship. As for peer review I'm not aware of the any official peer review program on the nurse or members of the nurse professional standards board, which is an archaic form of professional standards that has long outlived its usefulness if it ever had any. The nurses are not promoted by their peers or supervisors for the work they do, but rather how well the proficiency are written to these same standards. If you have a supervisor who is a good writer you stand a much better chance of getting promoted. Your supervisor nor anyone from your service line is allowed to vote on your promotion, although they are allowed to give input. How did nurses at your facility participate in clinical decision-making? Again, every clinical center service line is different. Mental health which is a service line that I belong to, we're asked or assigned to committees et cetera. I suppose we could theoretically have some input in the changes but my experience has been that the decision as made at other levels and we are asked or strongly encouraged to go along with them. Are there any changes that could be made to improve meaningful nurse participation in decision-making processes? I believe that until

nurses are given an equal footing in a decision-making process with other hospital administrators this will never happen. If we haven't been able to gain ground in this area as well as respect under the current nursing shortage crisis then we never will. And I don't see any change in our facility. The same nurses who are making decisions years ago are still for the most part making important decisions. Their titles may have changed, salaries have increased but they are still ineffectual leaders. Hospital administrators want it that way. They do not want anyone who makes waves. Of course this is no different than corporate America. Should it be? Well, if our product is patient care and our clients depend on our effectiveness sometimes with their lives then it should be different. How can we trust be better established? I believe the trust issue will not change until nurses are more empowered at bedside. As long nursing administrators make more money, they make the bulk of the decisions and discourage outspoken nurses from voicing their opinion there will never be trust. In theory, union help in allowing nurses to voice their opinions without repercussions but nursing administrators have long memories and will use union vehicles to punish nurses if need be. Trust can only improve with the equality. Hospital administrators introduce and mandates changes but never stop by the bedside to receive input from the nurses who are force to do integrate these changes into their practice, unless course it is a JCAHO visit or a politician happens to be in the area. I believe this would be a start. How can nursing staff facility better participate in decision-making and problem solving? At the unit level again apparently staff could be more involved in staffing scheduling decisions, giving them a piece the pie. Reward them for involvement for of good use of leave, et cetera. If they are given a budget for overtime they stay below the budget they should be rewarded. This money should not be shifted to a unit that abuses their overtime. Speaking to the staff and making them feel they are part of something instead of indentured servants would be a start. Nursing administrators forget they started at the bedside. At the organizational level, every nurse should have the opportunity to participate in corporate decisions. Bedside nurses should be represented in some way and not by nurse managers or nurse executives. Their view point is often interpreted as a voice of the bedside nurse and in most cases nothing could be farther from the truth. How can the VA best attract retain a quality work force? They could start by improving the salary at introductory levels. You do not find a lot of graduate nurses because the starting salary is not competitive. Until we begin to attract the younger work force we will not have younger and fresh ideas. I believe that while experience is a good thing, a mixture of experience and youth provides a better chance of success for the profession in general. Nurses have got to stop eating their young, as the expression goes. They need to start nurturing their young to maintain the longevity of the profession. There are entirely too many nursing administrators in general and certainly too many that have forgotten the reason they went into nursing to begin with. Make them accountable and perhaps you can retain a quality work force. I know. My example for over 10 years I have been involved in a modified self-Scheduling process. It has allowed nurses a measure of control and life outside of the hospital. Now attempt are being made the change this and staff moral has plummeted. This is my example. But I'm sure within the profession there are multiple examples. What is the central issue of concern to the VA pay administration? I'm not sure. I know what everyone else thinks about this. It's a different problem than what I think. I feel the central issue is related to the qualification standards. This is highly too difficult for nurses to get promoted in the VA system. I stated previously the nurse professional, as standard board is archaic. If

someone has an axe to grind with you and they happen to be on the board you're less likely to be promoted. In terms of technology. The VA seems to be using technology and it has been for some years. Our computerized patient records system, which is available at our VA. I'm not sure it is available nationwide is extremely valuable tool. However as in all equipment things break down and need to be replaced. Support for this technology seems to be lacking probably because of funding. When a PC malfunctions we have to wait days or weeks to replace or have it repaired. The bar code administration system is the same. We were not asked for input about it. We're informed that we must begin to use it and we had to suffer through its frequent problems every since. While nurses receive some training on these systems it's cursory at best. Leaving the bedside more detailed training as an option that is made available but sometimes is unrealistic based on staffing needs. Usually these courses are offered eight to four. If you are on night or evenings you're out of luck. Why and that is because the administrators are the people that are teaching those courses. They work 8 to 4:30 and I'm sure at some point in their profession they did work those other off tours. I believe that technology is good in general but I see the aging work force struggle with this because many of us are not from the computer generation. I am self-taught and more computer literate than most of the nursing staffs with whom I work but by no means am I an expert. Even with these technological advances I feel sometimes if I taking care of computers instead of patients. Again hiring younger nurses, new graduates with computer backgrounds would certainly be beneficial to the VA. Having staff who develop new templates for documentation, et cetera, come to the units and get feedback from the nurses would help as well. Right now they implement something, send us direction and expect us to be proficient in using it. People remain hesitate to complain because complaints about change within the VA by my experience are seemingly frowned upon. You become labeled as a complainer. I would simply close by saying if input were encouraged before implementation resistance to change would be less.

DR. PATTILLO:

Thank you.

MR. DANDRIDGE:

I have one question and you probably addressed it in your testimony as you progressed. But you made a statement and that was that you believe and until nurses are given an equal footing in the decision-making. I would like you to expound on that, in terms of some of your thoughts as far as how that could best take place?

MR. HOLDEN:

I believe that nurses need to be given an environment in which they feel they can openly speak to their supervisors -- to their superiors, without worrying about a verbal counseling without being told that Well, this just the way it is. I'm currently involved in a dispute with my management which exemplifies that point in the sense that they wanted to change the format of our scheduling and our process which has been proven over 10 years to be cost effective. And they didn't come to the staff and say, What do you think about how we can improve on this? How do you think we could decrease overtime, et cetera, et cetera? They just showed up one day and handed me a new disk and said, Use it. These are the types of things that I

think that people react to and there is lot of reactivity. Managers need to be better trained is one thing. They need to take some sensitivity courses. I believe they need to work some weekends. I believe they need to come back to the bedside a little bit and see what it is like to deal with what we have to deal with on a regular basis. I don't expect them to be proficient no more than I could be pooled to a SICU and know what I was doing. However they could show up once in a while and I believe that that's a start.

MR. DANDRIDGE:

You also described the organizational context in which nurses or nursing finds itself in, not to paraphrase you but I guess I would kind of paraphrase you as saying diluted or de compartmentalized. Can you share with me your thoughts in terms of the impact that you believe that has and what you think should be done to address that?

MR. HOLDEN:

Well, I believe primarily the input relates to having MDs or psychologists in charge of your department who really do not have any idea what it takes to manage an inpatient unit on a24-hour basis. And because of that, they assume that whatever the nurse executive or nurse manager is telling them is the word of law by nursing and as I mentioned by no means is that true. Many times nurse managers and nurse administrators are in the in touch enough with their staff, although they should be, and I think that depends on managers. I worked for some managers that were very good and very much in touch. I have also managed myself. When I managed I very rarely ever left at 4:30. I worked weekends. I worked days and that was my choice. I worked evening shifts. I was there if the staff was shorthand, I stayed and I helped the staff. I don't expect every manager to do that but I was committed to that staff for the short period of time that I did that and the staff knew that. And they knew they could depend on me. And there are many instances now where they will call me before they will call the nurse manager, simply because they know I am reliable, dependable. I don't think management takes that perspective. They get to that point where they are given the Monday through Friday job and every weekend off, every holiday off. That's a pretty good benefit right there. Why do they need to make $10, $20,000 more than we to? If the shortage is at the bedside that is where the money should be, okay.

MR. DANDRIDGE:

Thank you.

DR. PATTILLO:

Thank you very much. Okay. LaVerne English, Pittsburgh PA Healthcare System.

MS. ENGLISH:

Good morning. My name is LaVerne English. I'm too from the Pittsburgh VA health system. I have been an RN for 32 years. I have had a total of 14 years of VA experience. The question I'm going to address is of the professional incentives. Does the VA have the financial professional

incentives to attract retain a skilled nursing work force? And my answer to that is no. The opportunity for promotion and advancement appears not to be present at the VA. However there is a false ceiling placed on promotion by management using the educational requirements. Although there have been provisions made for waivers for certain requirements of the quality standards, no waivers have been made for education in our facility. Thus, nurses who do not meet certain educational requirements and function at high clinical level are not rewarded or promoted for their clinical expertise. Currently 60 percent of the clinical nurses practicing in the U.S. are diploma or AD grad nurses. An example of this is my own experience. I have been a practicing RN for32 years. I am graduate of a diploma school. I have also obtained a hundred credits towards my BSN. My life situation however has prevented me from finishing my degree. I have had three separate working experiences at the VA. I first came to the VA as new graduate in 1971. I worked there from 1971 to 1980. I was the head nurse on the 40 bed surgical specialized unit at the time I left employment at VA. I accepted a management position and as nursing supervisor at a 120 bed skilled nursing facility. I returned to the VA in 1983. I functioned as a staff nurse on a 40-bed general surgery unit. I was also Simultaneously functioning as the PRN night supervisor. So generally I functioned as staff Nurse three days a week and as the nursing supervisor two nights a week. The last three months of my second term of employment I functioned as the acting head nurse on the surgical unit. At this time my grade was an intermediate grade or as current standards go I was a level II nurse. I returned to the VA in January of2001. When I returned to the VA the nurse recruiter that I cannot be brought in as a Level II nurse because I did not have a BSN informed me. I could not be grand fathered in even though I was at level II nurse position when I left the VA. Since I have returned to the VA I have functioned as a staff nurse on a 36-bed12 specialty surgical unit, which included a full observation bed unit. I worked on that unit for a period of 16 months. My proficiency ratings for that period of time were highly satisfactory, outstanding, highly satisfactory. This proficiency rating is based on the quality standards of a Level II nurse. At end of the 16 months I transferred to the primary care clinic. My proficiency in the clinic there is also based on a Level II nursing standards. This rating is scored as an outstanding rating. I have been denied a promotion to a Level II nurse because I lacked the education requirements of a BSN. To date there not been a waiver of this component in the quality standards at our institution that I know of. Although provisions for this has been provided when the standards were instituted. I feel this is grossly unjust. I am functioning in an outstanding capacity as Level II nurse. I'm being paid as a Level I nurse's salary. This leaves little chance for promotion until the time I retire. I have functioned in management and staff positions. I feel this is management's way of keeping the budget down. I feel that under the current nursing shortage crisis and the recruitment for nurses in the private sector it will be impossible for the VA to retain a skilled nursing nurse force. I fell this is to the detriment of the VA patient. My recommendation would be to the relax the current educational requirement and the quality standards. I would also recommend allowing the bargaining unit to represent nurses in application for a waiver of the standards to increase promotions.

DR. PATTILLO:

Why did you leave from 1980 to '83 if that is what you said?

MS. ENGLISH:

I accepted what I thought was a higher management position. I thought it was an excellent opportunity for me.

DR. PATTILLO:

And you came back to the VA?

MS. ENGLISH:

I came back to the VA.

DR. PATTILLO:

Because?

MS. ENGLISH:

To me the VA is home. I feel very comfortable there. I feel the VA Nursing work force is an excellent nursing work force.

DR. PATTILLO:

And you left in '83 and when did you return -- I mean, when did you leave at that second –

MS. ENGLISH:

I went on maternity leave so actually I left in '86 but did not resign until '87. And the reason I least the second time was because I was in my late30s 30 when I had my children and I didn't feel I had the physical stamina to work full-time at the VA and raise children.

DR. PATTILLO:

I understand. Thank you very much. Okay, we have open forum till 12 o'clock. Thelma Roach-Serry.

MS. ROACH-SERRY:

Good morning. First of all, thank you for permitting me the opportunity to sit before you and voice my view about nursing in the VA. I am Thelma Roach-Serry. I am a registered nurse with 20 years of experience. I'm currently a nurse manager in the Richmond VA medical center in Richmond, Virginia and have been serving in that role for the past 13 years. I'm a member of the Nurses Organization of Veterans Affairs - NOVA. I want to say that I'm very proud to work in the VA system, the largest employer of nurses in the United States. And I'm even more proud to be a part of a national system that provides health care to our veterans. For without these men and women the system would not exist. Nursing conditions in the VA are in need continued improvement. I believe that we need to support systems that allow nurses the abilities to provide the best care possible. Nurses are working with equipment that need to be updated, without having to go through the red tape of having to lend priority to what equipment can be purchased now versus what can wait to be purchased later. What I'm referring to when I say nurses need to be allowed to do nursing they need

to be able to be at the bedside to provide nursing care. We quite often as the previous speakers have mentioned we're inundated with tasks that are non-nurse related. We need to be given the time to be able to do nursing care. Inpatient nursing personnel are over worked and worked in conditions that negatively impact on patient outcomes. As a former nurse manager of an acute medical unit and now the nurse manager of several ambulatory care clinics including emergency room, I have seen the demand placed on nurses and it has increased. Nurses in the outpatient setting are required to do more with less time and the same resources. The volume of patients seen has increased tremendously and the demands for access to care have profoundly impacted on the need for nursing care and outpatient settings. Additional nursing resources are needed. These nurses need to be well trained and the nurses need to be allowed time to do nursing care with patients. I would also like to mention something in regards to educational funding. Increase funding needs to be provided to train our nursing personnel. Nurses need to have their skills updated with regularity. Nurses needs to remain abreast to have state of the art advances in nursing. Opportunities must be maintained and allow nurses to advance their careers through the obtainment of advanced degrees and certification, which makes them prime candidates for other positions within the VA. National education funds needs to be made available to all nurses without restrictions being placed at individual facilities. I'm proud to say that I'm an EI recipient and if time lends the opportunity for me because I do work long hours. I'm a nurse manager who stays. I work 12, 15-hour days. I do come in and provide assistance to the staff on weekends. But if I complete my Master's degree I will have a Master's degree in health administration. Another concern that I have is retention efforts. We must provide incentives for nursing personnel to stay in the VA system. Internships programs that used to exist or may still exist but aren't publicly advertised or used in certain facilities need to be reinstituted or maintained. I know of an excellent nurse who worked in the system who was graduate nurse technician who was allowed to work in the VA pending her receiving her licensure. This nurse has stayed in the system, has worked in the system for almost 18 years. She has worked at the bedside, various settings and outpatient settings and now she is a research nurse. She is a star in the system that continues to rise in the system. Thank you very much.

DR. PATTILLO:

Thank you so much. Beverly Ross.

MS. ROSS:

Good morning. I'm Beverly Ross and I serve in the role as psychiatric clinical nurse specialist and women veterans program manager at the McQuire VA medical center in Richmond, Virginia. Thank you for this opportunity to come before you to speak on issues that are significant to VA nurses. I'm also on the board of directors of NOVA and I am speaking as a representative of this organization as well. I would like the address the issue of advancement for advanced practice nurses. These are nurses in the positions of clinical nurse specialist and nurse’s practitioners. Currently the opportunity exists only for nurses to advance on an administrative level, although the VA has discontinued its associate chief nurse training program. I strongly recommended that the development of a clinical route for nurses who have a clinical focus and provide direct patient care. There exists a large number of nurses at facilities who have topped out at

the Nurse III, step 12 level, but cannot advance to Nurse IV because they do not have supervisory responsibilities. We have recommended a specialty pay schedule for APNs at my facility, and in spite of the fact that a specialty pay schedule exist for APNs at all other facilities within our division, division six we were turned down. The denial was based on the fact that we have no recruitment or retention problems for APNs at our facility. The complexity of the role was not considered nor the advance preparation for the position. Denials such as these cause problems with moral, for individuals that are committed the providing quality care to our veterans. I would also like to recommend the development of a specialty pay schedule for all advanced practice nurses on a nationwide basis based on the complexity of the role, the master's degree requirement, prescriptive authority and the function as a licensed independent practitioner. I would also like the address the peer review process. The nurse professional standards board should be maintained to establish a fair means of determining appointments and promotion of staff. It is now required that a PN serve on the board. This is long overdue. The process needs to be an objective one and this has not been consistently the case for all nurses. There should be oversight of the board that does not currently exist. Periodic reviews of decisions should be conducted to ensure that consistency and fairness are carried out. Do not eliminate this process but improve it. Nursing education. I serve on our medical centers and NEEI committee. This initiative will stop in 2005. Just as nursing is again in the throngs of a shortage. Encouraging and empowering nurses to continue their education, to allow for even greater opportunities and improve service to veterans is hard to fathom. Individuals who work full-time and care for their families should be provided with some incentive to continue with the desire to achieve. Programs such as the NEEI and valid programs should be embellished to allow even greater numbers of qualified nurses to provide care to our veterans. In order for the nursing profession to be recognized as such by other health professions we must continue to assist nurses to receive their BSN. I recommend that the commission continue the NEEI and valid programs or at the very least develop similar programs that will motivate nurses and assist with the recruitment and retention of quality VA nurses.

DR. PATTILLO:

Thank you so much. Do you have questions?

MR. DANDRIDGE:

No, I don't.

DR. PATTILLO:

Thank you so much. Sharon Dudley.

MS. DUDLEY:

Good morning. My name is Sharon Dudley. I am employed at the VA Hudson Valley, the Castle Point, New York campus. I have been employed by the VA for11 years. My subject is recruitment and retention. I'm a LPN. I'm working as a nursing assistant. In the private sector I'm a LPN. The VA has paid for my education. Upon completion of my program I graduated with honors. I went to a apply for a GPN position and was told that there was no GPN positions available. They were not hiring GPNs. I left the VA

system to look around outside and I was accepted at a job making more money than I currently make at the VA. What I was currently offered at the VA as a LPN is less than what I currently make now. What I was told could be done for me is they could retain my pay until my status as a LPN reached my pay grade that I receive now. That is no reason for anyone to want to educate themselves to give back to the VA. I'm stuck. I'm in a position where I have to work two jobs. I have invested 11 years in the VA system. I'm now mandated to two more, and for that reason, I have to work two jobs. And I want to ask how will we going to pull more people into the VA, retain more people on a professional level when we don't take care of what we have?

MR. DANDRIDGE:

No questions, but I would make a comment. And I think the situation that you described is clearly one that affects people like you in nursing but also elsewhere in the organization as well. I think commensurate with our goal to be an employer of choice I think we really have to systemically address these issues across the spectrum. I mean GS 5 that goes and gets a master's degree in public affairs and then can't apply for a GS 9 unless they are told that they have to quit and reapply again that is not the answer.

MS. DUDLEY:

Even if I reapply my pay would be less than what I currently make now.

MR. DANDRIDGE:

Yes.

DR. PATTILLO:

Thank you very much. Deborah Beck.

MS. BECK:

I am Deborah Beck and serve as the executive director of the nurses organization of veterans affairs. I wish to thank the National Commission on VA Nursing for holding these hearings. NOVA is the professional organization of the approximately 35,000 registered nurses employed by the VA. NOVA's mission is to shape and influence health care within the VA. Along with this commission the Secretary has appointed a Cares Commission who is charged with developing a strategic plan for next 20 years to deal with the VA infrastructure. The VA's greatest asset is the health care team that works together to care for the nation's veterans. The primary motivation of VA nurses is to be able to provide quality care to their veteran’s patients. In fact a recent NOVA membership survey found that 90 percent of the respondents found the most rewarding aspect of their job was caring for veterans. Several impediments were cited as barriers to their practice and that included inadequate staffing, performing non nursing duties, lack of time and opportunity for education training, and inadequate technological support. In order for to be able the care for the aging veteran population 2010 and beyond it is critical for the VA be able to recruit nurses as well retain the nurses already in the system. NOVA held its annual meeting recently in Washington, D.C.. At that time I had the opportunity to discuss nursing issues with the attendees and I would like to share some of their comments with he commission. Many nurses echoed

their beliefs that the facility impacts the quality of care they are able to provide veterans. Nurses take pride in their work and it is difficult to be proud in an old environment with inferior equipment, mismatched furniture, old equipment and technology that does not function consistently. It is believed the facility has an impact on morale of the nursing work force. Nurse believe care will profoundly impact nurses in the field as facilities are closed or consolidated. The questions about how these actions would impact the mission of the VA. As facilities are closed job satisfaction may decrease which could lead to retention and recruitment problems. Both nurses and patients may have to travel greater distance to work or to receive health care. As the VA attempts to recruit new graduates in the system, the VA will be competing with state of art hospitals in the community. And in order for the VA to remain competitive it is believed that VHA aging facilities may negatively impact both the recruitment and retention of the VA Nursing work force. VA nurses support the effective and efficient use of the resources to provide care for our veterans. As nurses we know it is not reasonable to support very small inpatient units that cannot offer the complexity of the services today's health care environment requires and our veterans needs. It is critical however to include the nurses in planning those changes as it is the nurses who will be at the bedsides explaining to veterans how their care will be more comprehensive when delivered at a distant facility rather than their hometown VA Medical Center. It is the nurse who will provide appropriate support and education to patient and care givers so they can make this transition with the least disruption in services. The Care Commission will holding hearings in each in June and July. NOVA recommends the commission consider a Cares Implementation Task Force be formed whose purpose will be to oversee and make recommendations to Care during the implementation phase. I would further recommend nurses play an integral role in this task force. The nurses participants on the task force would bring clinical experience and insight into the ways to maintain and increase care to veterans as major changes are being made to the infrastructure of the VA and care to the veteran patients. Thank you.

DR. PATTILLO:

Thank you. I just want to remind the people who are participating in the open forum to submit their testimony because you have some very wonderful ideas and we want to make sure we have captured everything. Okay. So what we are going to do now is to recess for lunch and we will return at 1:30 maybe to a different room. (Whereupon, a luncheon recess was taken.)
AFTERNOON SESSION

MS. PATTILLO:

Let us get started this afternoon. For those of you who weren't here earlier this morning I just wanted to introduce myself and say I'm Dr. Pattillo and this is Mr. Dandridge. We're from the commission.

MS. PATTILLO:

For those who you weren't here in morning, I just wanted to introduce myself. I am Dr. Pattillo, this is Mr. Dandridge who is a visiting director and we're both on the commission. Ms. Moore, who is your executive director, Mr. Bob Swanson, policy analyst, Donna Shuler, human resources, central office. So feel free to talk to them also during the break if you wish. I think this is a good opportunity for us to share. And we've a

court reporter who wants to make sure you speak clearly so that everybody can hear and he can hear and slowly. Speaking of documents we encourage people to submit their written information if you are called or even if you are not called to provide testimony through our open Mike session or Open Form session and certainly we have a Web site. Anyway there is a flier somewhere that shows our Web site. We encourage you if you have any thoughts after the hearing like when you go home say, Oh, my gosh, I should have mentioned that you feel free to go ahead and e-mail us and write to us because we do take all this very seriously and we read through all this information and if there is a time to do it if you want to make sure your voice is heard. We really don't want to see the good things about the VA as well as our problems, okay, so we don't want you to feel that you are a whiner. We want you to be able to tell them that we're so valued and this is the work that we do and they cannot live without us. Okay, I want you to present your information in a good way to us as well as identifying the problems, which we want to know the problems so we can fix them. We can try it. So are there any questions before we begin? Well, thank you all for coming. Again, I appreciate those who came and paid their own way to be here taking your leave or vacation for us for you to be here. So we really appreciate that and thank you so much our first speaker is Helen Hanlon from Togus.

MS. HANLON:

Good afternoon. I am Helen Hanlon a registered nurse working at the VA Togus, Maine. I have been in nursing for nearly 40 years. I have been employed at the VA for almost 32. I really appreciate this opportunity to have you listening to us. It doesn't happen very often and we really appreciate this opportunity. My testimony today will cover two points. The first has to do with the need to abolish the current nurse qualification standards and, secondly, the need for the VA to address pay inequities for LPNs and nursing assistants. Regarding the nurse qualification standards the current pay promotion system for RNs is irrevocably broken. It should not be tweaked, it should not be modified, it should not be reconfigured. This has been tried, it has failed, it is as a disaster. It needs to be immediately replaced with a system that is fair, understandable, easily administered and audited. Even our center director, our chief medical officer in our human resources staff complained that this is a system that they simply do not understand. Besides promotion our annual locality pay adjustment is also based on the nurse qual standards. When we go out to the community to try and match jobs, we find that we can't explain our system to the communities. They have one-sentence job descriptions. We have paragraphs. And they simply don't match. And this is unfair to our dedicated nurses. They are penalized because of a system that just simply doesn't apply to the real medical community world outside the VA. This system is a single most often cited complaint our nurses have about their VA employment. Nurses at all levels mistrust the system with pay promotion and reward. They not believe that it is truly peer review. They resent the secrecy, the lack of accountability and oversight, and the lack of representation throughout the process. In my written testimony I submitted seven recent examples from our Togas VA facility. I won't review them here. But I believe that they represent the problems inherent in the system and the impact it has on the moral and the retention of our valued nursing staff. This is a system that frustrates rather than encourages and instead of motivating. We recently lost a terrific diploma grad with 20 years experience. She left because she did not have a BSN and knew that she would not get promoted. She is currently working at Maine Medical

Surgical, which is the largest medical center in Maine. She's making $15,000 more a year. She's a supervisor. And we have lost a truly remarkable nurse who is a leader, a clinical expert and the VA and the veterans have lost a wonderful employee. This is an example of what we're up against. The recommendations that I have are: One. The VA in conjunction with those who represent nurses should immediately develop a pay promotion system that rewards performance, years of services in lieu of the current nurse qualification standards. Two. Title 38 must be amended to allow for mandatory increase numbers of promotional steps. At this time VA facility directors have the opportunity to do that but it is rarely used. Three. The system of education achieved versus performance demonstrated must be revisited. Four. Reward and incentives should be developed in conjunction with nurse representatives to ensure fairness. Currently they are not received as being fair. Staff nurses should contribute to the performance ratings and review it with their supervisors. Staff nurses should be involved in the selection of nurse executives. We face a true leadership crisis in nursing. Six. Title 38 should be amended to allow nurses and others to recruit. The second area involves the importance of the fair and equitable treatment for our valued LPNs and nursing assistants. They provide hands on care to our veterans. They assist when there is an acute shortage and we value the work that they do. In our facility we have to work with staffing agencies and not only are they paid more but they are also allowed to control of their work schedules and they able to go to school and to take care of their families and responsibilities. A staff complaint is they feel that they are not appreciated, both in pay and by the attitudes of the nursing administration. LPNs are often paid less than nursing assistants and they are required to assume every grade of responsibilities. They feel out of touch and alone. The VA must understand that these employees are future nurses. They must be mentored with concern to advance in the system. Provide them with educational opportunities to enhance them to become nurses to take care of our veterans and give them a reason o stay. Above all they must be treated fairly.

Recommendation:

Before you can work weekends, I think you heard this before, including support staff should be receive the same Saturday premium pay as their coworkers. Pay rates and pay systems for LPNs must be corrected to compensate them for their responsibilities and their education. The current proposal for GS 7 I believe is really inadequate and really won't address the problem. Up front tuition fund should be available to all LPNS and nursing assistants to demonstrate a desire to enhance their nursing education. The union should be able to sit down with management to negotiate staffing levels and size for staff and patient safety laws governing part-time workers pay must be modified to pay overtime for hours worked in a day not per week. We currently have staffs that are mandated to work as much as an additional eight hours and they do not receive overtime pay. Workers must be compensated per hours worked according to applicable labor laws. The VA must be held accountable to abide by our U.S. labor laws. We have employees who are working tremendous amounts of free time and this is a deceptive system when a nurse practitioner comes in and works an additional 60 hours a week and yet her pay is based on being able to work 40 hour per week. And finally computerized time, scheduling programs should be developed implemented at each facility. I do have written statements from other nurses that at our facility that I would like very much to submit at this time. Thank you very much for listening.

DR. PATTILLO:

Thank you very much. Next speaker is Beatrice Nesmith.

MS. NESMITH:

Good afternoon. My name is Beatrice Nesmith. I'm employed at the Veterans Administration in Salisbury, North Carolina. I am proud to have worked for the VA for 28 years. Currently I am a GS 6 psychiatric crisis technician and I work on a speciality psychiatric incentive care unit for the acute mentally ill veterans. As a health care technician I am part of the nursing care team on our eight-bed lock down unit. I typically provide special observation and diversity activity for patients. These patients are suicidal, homicidal and acting out or either brought in on holding orders and they are admitted to my unit. I am grateful for the opportunity to voice concerns for the nursing assistants and the health care technicians from my facility. When a registered nurse or a licensed practical nurse work Saturdays or Sunday shift he or she is paid a premium rate for those weekend shifts. The premium rate is set by law not VA policy. The premium is an additional 25 percent of their hourly rate. The premium not for overtime but for working a regular shift on the weekends. Technicians like myself, nursing assistants and other employees who keep the medical center running 24/7 do not get Saturday premium pay. We do get Sunday premium pay for working a regular shift on Sundays but the law prohibits us from getting Saturday premium pay. I have worked up to five weekends in a row as well so as many of my colleagues and it makes no sense that the RNs and LPNs on my floor get Saturday and Sunday premium pay but we only get Sunday premium pay. The situation sends a negative message to nursing assistants and patient care technicians like myself. Why would Congress and the VA want to say your Saturdays are not considered as important as the Saturdays of others? The certified patient care technicians and nursing assistants all have duties that are key to direct patient care. We're all part of the nursing team, which is a backbone of patient care. I believe this injustice in the law is hurting morale and staffing. People often call in on the weekend but will come in on Sundays because they know that they're going to get their weekend shift differential. Saturday premium pay could relieve of some of the burden, mandated overtime generated by calling in because health care technicians and nursing assistants seldom receive any recognition for a job well done. Saturday premium pay could get excellent replacement for a pat on the back. I ask that the commission seriously consider that recommending to Congress that they change this law to provide Saturday premium pay for all medical center employees who are required to work a regular shift on Saturdays. There also is an inequity in the evening and night shift differential. I am mandated to work beyond my normal tour of duty, which is 8:00 a.m. To 4:00 p.m. Under these circumstances when I work a double shift I only receive eight hours of overtime. I do not receive the evening shift differential. And RN under these same circumstances would receive shift differential. Working an off tour is working and off tour regardless of when it is scheduled. In fact, it is more often problematic when you find out at the last minutes that you have to be forced to stay over for an additional eight hours to continue to have adequate staffing on the floor to continue to provide quality care to our veterans. You have no time to plan for yourself an extra meal, change of clothing or even make family arrangements. I am not sure if this injustice is because of law or VA policy. I ask that the commission please consider recommending the needed changes to make sure that all staff who are

mandated an extra tour of duty receive a shift differential and overtime pay. As nursing staff leave or if they are retiring they are not being replaced. This exacerbates the shortage of staff which increases burn out and on the job injuries. I am on my facilities safety committee and we're often so short staffed that nursing staff are not allowed to go to our designated classes that are designated to train and to help us to use proper and safe techniques. I urge the commission to look into policy changes for all nursing staff. Under staffing also makes it next to impossible to achieve the mandated education goal of 40 continuing credit hours per year. We're not able to attend basic classes such as basic life support, prevention and management of disruptive behavior, computer classes, workshops, in services, et cetera. These classes help keep staff at their peak performance level, the opportunity to increase the knowledge base is an ongoing motivator, not only does it make the employee feel good about themselves but the veteran also benefits from the increased skills of the employee. It is very disheartening when you reach a level or a pay grade at which you can go no higher. It doesn't matter how much you improve your knowledge or skills, if you have topped out you cannot advance. There is not enough equal, there is not enough opportunity or incentive for advancement into a higher paying job. For example, when the certified patient care technician or nursing assistants who are providing direct patient care to our veterans and emotional support for families reach a level of a grade 6, they can go no further. Once the GS 6 step is met you are locked into a salary that have no hopes for advancement, if you wish to stay in the patient care field as a direct patient care provider. I ask that the commission look at the VA's upward mobility plan and see if the managers are being held accountable for meeting these efforts. I also ask that the commission look into the VA's efforts at all facilities regarding the diversity. Nursing staff of all races should be included in leadership development and participate in all committees. There needs to be a continued emphasis on the promotion of equality for all races within the VA system so that no one is overlooked and fairness is maintained. Our mission statements say that we will provide high quality, patient focus, cost effective health care for veterans. And in order to achieve this mission, we must address these issues and implement changes so that we can truly become a leader in health care and the employer of choice. Our hope is that we continue to achieve to make our goal putting our veterans first. I want to thank you.

MR. DANDRIDGE:

I wanted to ask you to little bit or comment about the inadequacy of the diversity. You were speaking in terms of various were you referring to something beyond that? Committees.

MS. NESMITH:

No, that is what I was referring to. I just feel as though it should be equal. I mean we have quite a few Blacks and Hispanics and Indians, I mean different races at the VA that I work at. But a lot of times when you see that, you know there is a lot of committees that are being formed you tend to see that perhaps maybe there may be more Whites compared to maybe just one or two Blacks or one Hispanic or maybe not at all. And everybody needs a chance. Everybody needs to have a opportunity to have a voice to say and so I feel as though everything should be looked at equally.

MR. DANDRIDGE:

Also your comment about first of all your recommendation about how to address the premium pay disparity I think was very precise, very clear. But also you indicated that there are people who are asked to work overtime and because they're not on a regular Schedule F they are working overtime during a period which they would ordinarily be eligible for premium pay then they don't get it I guess is what you said.

MS. NESMITH:

That's true. What we were told if your overtime is not planned say –

MR. DANDRIDGE:

Two week ahead.

MS. NESMITH:

Two to three weeks in advance then you can't get a shift differential and that is ridiculous because you can be forced to work over at any time. So I mean if I am forced to work over I want my overtime and my shift differential. You can even plan two weeks or three weeks in advance for

DR. PATTILLO:

It shouldn't be. Overtime.

MS. NESMITH:

No. But we are denied. Thank you

DR. PATTILLO:

I have a couple of. Questions. In terms of diversity -- my definition of diversity is we need more nurses on these committees. So competency versus race. I think we should have a discipline level of diversity, no matter what the color.

MS. NESMITH:

True.

DR. PATTILLO:

And we want the best people on those committees that represent nursing very well. And the other thing in terms of your 40 hours of CE is that a VA rule?

MS. NESMITH:

Yes. DR. PATTILLO: For nurse aides, too

MS. NESMITH:

Yes. We're too short staffed they say or even if they are scheduled to go. No, sorry somebody called in so you can't make it today.

DR. PATTILLO:

Well, thank you. I'm learning a lot. Thank you. Mary Lou Flanagan

MS. FLANAGAN:

My name is Mary Lou Flanagan. I am from VA Hudson Valley Health Care System. I have 14 years of experience as a LPN there at Castle Point. I'm speaking for all of the LPNs not only at Castle Point and Montrose but I'm sure all over the country. When I say that licensed practical nurses are many things to many people. The VA can attract and retain LPNs by treating them as nurses, not glorified nursing assistants. LPNs are staff nurses, med nurses; outpatient nurses, OR nurses and in many cases the front line patient advocate. Why then should the LPN be made to feel like a second-class citizen in the VA system? The LPN falls somewhere between the RN and making use of their license when needed and the nursing assistant. The LPN in most cases is not even recognized as a nurse. I'm sure you have heard testimony from some people who will refer to us as the lower paid and less skilled employees being substituted for an RN because we're cheaper to hire. This is the VA's mentality. If we accomplish nothing else by coming here to the nursing commission hearings, let it be that you listened to the voices of the licensed practical nurses who are asking for the recognition they so dearly deserve. The LPN's GS pay scale is antiquated. It has to be expanded to take into consideration the qualification and responsibilities of today's LPNs. Please tell me how a VA can expect to hire and retain LPNs when clerical staff and nursing assistants make more than they do. This is happening at Castle Point and I'm sure it is happening at other facilities, too. The GS 7 has just been signed by the Secretary Principal. This is a good start but it should not stop there. The HAS staff such as team associates are Grade 7s and can attain Grade 9, then the LPN should be available to attain a least a Grade 9. After all the state license is not a requirement of their job, but it is for the LPN. Another issue showing the huge gap between the RN and the LPN in the VA system is that the RN earns eight hours annual leave right out of school. The LPN must work for 15 years to earn that same eight hours of annual leave. This is just another way the LPN is made to feel different from the real nurses. LPNs realize that we're not RNs, we're not trying to be RNs, but we're nurses, too, and we think we deserve to be recognized as such. To my knowledge, nurses have little if any input in the decision-making process. Nurses have complained about staffing for years but to no avail. Staffing levels impact all areas of nursing even in the outpatient clinics where I work. Staffing barely is adequate. If someone calls in sick, then one nurse is expected to cover, one or even two doctors as well as nurse visits. That might not sound like much on paper but with all the JACHO requirements that must be met in the computer for each patient plus telephone calls, walk-in patients without appointments, medication problems, et cetera. Patient cannot be given the proper time an attention they deserve. When asked about more staff we're told that we have enough. Nurses on light duty count as full-time employees, when in fact they can't do patient care. Some cannot have patient contact at all. Numbers look good on paper but I invite those people who count those numbers to come on down to the floors where it really counts. Then tell me we have enough staff How can trust be better

established. and maintained? Trust is a basic instinct but trust must be earned. Administration has the history of saying one thing and doing another. Honesty comes first trust will follow. Education and training are very important issues but as I see it the people who need and want the training the most are the ones who can't go to the classes. Those nursing personnel who are working with patients are the ones who find it most difficult to attend classes and training due to the lack of staffing to cover them while they are away from their assigned duties. Therefore they don't go. The upward mobility program way wonderful for people who could not afford to go to school if they had to work or due to the child care issues did not go to school at night. Many good RNs came out of the upward mobility program. And we would like to see it brought back as soon as possible. I feel the central issue of concern in the VA pay administration is the GS system of grade levels, which I feel prohibits the LPN from advancement. Grade 6 step 10 is as far as we can go at this point. No matter how much experience, no matter how many years on the job. Now you tell me where the incentive is there. The most an LPN gets when we discuss advancement is to go back to school and get your RN. What the VA doesn't seem to understand is that people actually are proud to be LPNs. Some of us don't want to become RNs. That doesn't mean that we don't want the opportunity to advance in our own field. The upward mobility program for those who wanted to go on for their RN was a wonderful thing, but that is no longer an option. But does that mean that we should not be allowed to advance up the same scale as secretaries and clerks do? The GS 7, which was signed, is a step forward, but why should it stop there. If a clerk can advance to a GS 7 or 9, should the LPN not be given the same opportunity within our field? The clerical job description can be written very liberally by management when they feel the need. But it literally takes an act of Congress to get the LPN the same grade. New York State recognizes LPNs as professionals. Not so in the VA system. We're looked at, as hybrids not exactly a GS but not exactly Title 38 either. The LPN is required to hold a New York state license, as is the RN. They should be both rewarded and compensated for that license. No one is suggesting that the LPN be paid or compensated in the same way as the RN. We respect all our RNs and my intention is in no way to insult or belittle the RN position and responsibility of that position. We would like to stand together in our battle with the system, but the LPN is a very useful commodity to the VA that takes advantage of us whenever possible. We have a license where there is a need for a mid nurse but we also can be used for bedside care. We can be used in clerical areas for vaccinations, patient teaching and preventive health screening. When the VA speaks about VA nurses they should be speaking about both, RNs and LPNs. If you want an RN ask for one by all means, but please remember that LPNs are nurses, too.

MR. DANDRIDGE:

This is not really a question. I can appreciate your testimony,
And that on of the things that we wanted to do was to encourage all of you to use the Web site and if you have additional thoughts based on things that you heard others say that you believe would be beneficial for us to hear by all means make sure that you get that in to us through the Web site. Also, some of your comments, your suggestions were more specific than others. Step back take a look at them to the degree you can be more specific to the some of things that you believe could make a difference. I would highly encourage all of you to do so because that can be a valuable tool for commission as well.

DR. PATTILLO:

What does HIS mean?

MS. FLANAGAN:

HAS. That means that is the actual human administration system. Actually they are clerical people.

DR. PATTILLO:

And LPNs do or LPNs IV therapy?

MS. FLANAGAN:

In some places. It depends on your facility. I mean, but it is a bone of contention to say the least.

DR. PATTILLO:

Bob Swanson here and some of his staff could go to the units to really count the nurses that are actually working people from the office of management and budget, OMB. Thank you so much. Our next speaker is Susan Pahl.

MS. PAHL:

My name I Susan Pahl and I am the nurse at Buffalo VA Medical Center where I work as a staff nurse and charge nurse taking care of cardiac patients who have coronary artery disease. My patient comes from all over western New York to visit. I'm also an active member of my unit to the New York state nurses association and our National United American Nurses. Today I'm testifying as a proud VA nurse on behalf of 6,000 VA nurses of the United American Nurses. I believe this hearing, last week's hearing in New Orleans and the two hearings yet to come will be critically important if you develop strategies that will attract new nurses to VA nursing and retain the excellent nurses currently on staff caring for our nation's veterans. As you know we are facing a nurse staffing shortage that will reach crisis proportions in the next few years and the VA system is no exception I became a registered nurse in 1975. Through a three year diploma. Since then I have spent 27 of these years in Buffalo VA and 12 years as a staff nurse. As a staff nurse in the grade of Nurse II at the VA assess patients before, during and after I coronary procedures. Patients typically with multiple medical problems they are acutely ill veterans with symptoms occasioned to undergo this invasive procedure. They may have had myocardial infarction. These surgical procedures require ACL intervention during the procedure. About nine months ago my head nurse retired and while a new head nurse was brought on I was also was designated as a charge or lead nurse for the cardiac care lab and performed many of the administrative tasks that the previous head nurse at my facility performed. In addition to my staff nurse duties I am also now responsible for time schedules, developing quality assurance monitoring and changing patient processes among other tasks. It will not surprise you to hear me say that I love my job and the work that I to. I would not trade the opportunity to work with the critical ill veterans I see every day. However I find myself in a difficult situation that is not at all unique to the VA nursing

system. I'm currently a Nurse II. With the addition diagnosis my new charge nurse duties I desire a promotion to the Nurse III, since I met the Nurse III performance criteria spelled out in the nurse qual standards. Because of the arbitrary way in which the qual standards are applied and the clinical biases I may or may not receive my promotion. Today I would like to address the issue nurse qual standards and their application if they relate to promotion. On a larger scale the situation has broad implications in the nursing system to attract and retain quality registered nurses to the VA. Nurse qual standards are the foundation for what I do every day as nurse. Nurse qual standards are tremendously important in spelling out my practice, my responsibility and my expectations as a VA nurse in terms of nursing practice. I'm not suggesting that we get rid of the qual standards, but I do encourage you as members of the commission to take a higher look at how the standards are applied to the promotion process of VA nurses. The nurse professional standards board is supposed to be made up of peers who have retained the grade to which the nurse desires promotion, or a higher grade who are charged with the responsibilities of deciding whether or not you should be promoted. In reality the board is anything but a peer review process. Typically it includes Nurse III supervisors and others not currently in clinical practice. I have found that are some that are not adequately trained in the application of the dimension of nurse qual standards. The arbitrary denial progression based on the nurse's lack of bachelor's degree is having a profound effect on new nurses coming out of two year nursing programs. And who may choose not to consider a Nurse I position at the VA observing how hard it would be for them to move up the classification ladder referring to my own situation, I maybe denied promotion to Nurse III according to the standards of a Nurse III without a master's degree or a waiver saying that I have met the nine qualification without a higher degree. Even though the requirement for Bachelor's and Master's degree and the waiver process for existing employees seeking promotion to Bachelor's in 2005 many facilities have done so from the introduction of the new standards in 2000. I hope that my director will make an honest assessment of my skills and determine that my daily work and the responsibilities qualify me for Nurse III. But medical directors can have discretion over these promotions. They may do or not do so for reasons that are entirely unrelated to how qualified the candidate is. Directors typically have far more latitude in determining who warrants promotion than was initially intended in the qual standards. The qual standards themselves based on which promotions are given are also in many cases arbitrarily applied, interpreted and enforced. The commission should review the qual standards that they apply to the clinically based nurses with an eye towards how clinically based standards themselves are. Unfortunately in many instances directors and managers have used the qual standards against nurses seeking advancement to limit opportunity or a promotion. I want add that nurses seeking advancement in the VA the difficulty in moving up the grade is not just about the pay increase. Nurses do what we do because we are dedicated to patient care and our profession as nurses in the VA we have a commitment to provide top quality care to our nations veterans. Being a VA nurse is what I have ascribed to be. We have significant opportunity to work with you the members of the commission to create a work environment that will help us attract and retain registered nurses. I and other VA nurses believe the commission should address how promotion and the application of the nurse qual standards can help create a place where nurses will want to work. In the long term including the work environment at VA facility is the strategy that a staff with a growing shortage that registered nurses are willing to make a career out of being bedside nurses. I thank you

MR. DANDRIDGE:

Would you elaborate? For me on your comment regarding the systems that are available are rarely used to help to differentiate I guess the qualifications of those being considered?

MS. PAHL:

Step increases. Nurses can be given step increases as part of the award system. I sit on the committee at my facility, peer review committee for awards, and I have not once in three years seen a nurse put in for a step increase

DR. PATTILLO:

Thank you very much. Okay, we have an opportunity here for an open mike. So our first presenter is Jacqueline Parrish.

MS. PARRISH:

I would like to thank you for the opportunity to address some concerns here today for allowing me to address a couple of concerns for the LPN and the NAs. My name is Jacqueline Parrish. I'm a 20-year veteran of the United States Army. I was hired at the Durham VA 15 years ago, as a LPN there. I'm interested in the new GS 7 standards for LPNs that are long overdue. They are here now. But I'm concerned that those GS 7 standards won't be reachable with the LPNs. So that the recommendation I have for that is I'm recommending that some process will be developed that will ensure every LPNL the opportunity to achieve the GS 7 that has now been released. For the NAs. I'm concerned with the NAs because premium pay for nursing assistants is my concern. None of the Title5 employees receive premium pay. But are required to work weekends with LPNs and RNs. Recommendation for that is my recommendation to the committee is to change the law to guarantee every employee who works a regular schedule on Saturdays receive premium pay. I thank you for this time.

DR. PATTILLO:

You know we're very interested in comments being based on practice. And so with LPNs it would be very helpful all LPNs get together and to see what a GS 7 would look like versus a GS 5 in terms of compensation. You should get a group together and maybe make those recommendations to us and we can look at all that but that should start from the LPNs themselves to be able to differentiate what a seven would be versus a five.

MS. PARRISH:

That is what we're doing at this time.

DR. PATTILLO:

Good.

MS. PARRISH:

We will be presenting them towards the end of month.

DR. PATTILLO:

Great. Thank you so much. Hogue.

MS. HOGUE:

Good afternoon. My name is Essie Hogue. I am a registered nurse. I have worked my way there from a NA to LPN to RN, BSN. I have seven half years in the private sector. I have 25 years with the VA medical center in Saulsberry, North Carolina. My subject is dealing with the qualifications standards. I would like to see them done away with. The reason being regardless of the entry-level interpretation registered nurse we all take the same licensing exams in class through the state board of nursing. Associate degree nurses receive approximately 24 months of classroom and clinical training while the BSN receives approximately 36 months of classroom clinical training. And the State of North Carolina the pass-fail for 2002 for the first time candidates was 86.7 percent passed. Likewise for the BSN first time candidates for 2002 was 86.7 percent who passed. That is pretty equal. Many VAs have a policy not hiring below the BSN degrees. Their hiring practices stifle the professional opportunities of the AENs, LPNs and NAAs. It discourages LPNs from continuing their career in nursing. Veterans who receive that care from these nurses do not call for a BSN or a AEN. They simply for a nurse and hope that they are qualified to care for them. The new standards have put us back at the mercy of our hand picked peers who use an invincible needle of personal opinion to determine who measures up and who doesn't. Therefore favors and cronyism raises its ugly head again. We see the present prospects as too punitive. Nurses who have no means of achieving higher degrees have difficulty getting off work or childcare to get there. Nurses who are denied promotions year after year it causes disgruntled employees whose focus somewhat swayed from patient care to self. This leads to increased personal conflicts on the job, increased sick leave usage and increased on the job injuries. When RNs with BSNs and LPNs work side by side getting the same daily assignment and giving the same quality of care to their patients they should get the same promotional consideration but it appears that the degree is mightier than the experience and the expertise. I compared the nursing professional standards board to a slam-dunk contest. It matters not how skilled you are at playing the game. If the judges are of the personal opinion that you do not measure up you can slam-dunk until the cows come home and have only milk at the end of day. The qualifications standards need to go away. I recommend abolishing the standards, developing a process that removes favoritism and cronyism, use time in grade. If a nurse not on a process improvement plan, then that nurse time in grade should be promoted until she reaches her maximum. Abolish the standards. Do something. The present process does not work.

DR. PATTILLO:

Thank you.

MS. HOGUE:

Thank you.

DR. PATTILLO:

Linda Mitchell.

MS. MITCHELL:

I am Linda Mitchell, and LPN. I worked two of the three Pittsburgh VA facilities since 1983. I'm a fellow Title 5 employee. Every one reports for duty on off tours just as do the Title38s. We perform our assigned duties as directed and oftentimes more if needed for our veterans. This is a issue of shift differential and it is delivered. Title 38s receive differential when they start their tour and they continue until completion. Title 5s and hybrid 38s, which I am one of, we do not. We're required to work two and a half hours at the start of an evening tour before we receive the differential and do not receive this differential after 6:00 a.m. when you are working on a night tour. There are still two hours remaining before the end you can go home. We're asking for equitable treatment. I believe with equity the VA can increase staffing morale. When there is incentive there will be employees who will do well. As GS employees we report the work on Saturdays and Sundays. Hybrids have just begun to receive Saturday premiums. Other Title 5s continue to receive only Sunday pay. Although care is provided on Saturday as well as Sunday to our veterans, management has either overlooked or ignored these employees who continue to work side by side with the rest of us. And in doing so we ask this commission to recommend changes in the law to guarantee premium pay for Saturday for all GS employees. Thank you.

DR. PATTILLO:

Thank you very much. Annie Green, Brooklyn VA Medical Center.

MS. GREEN:

Good afternoon. My name is Annie Green. I'm from the division three Harbor, New York Harbor, Brooklyn VA Medical Center. My testimony that I want to is, number one, staffing. As we know many before me have spoken on staffing. We need adequate staffing for the day, the evening, and the night tour at all times. Because when there is not adequate staffing the patient suffers. The issue of floating. When you go to work if there is a shortage in another unit or another floor and your unit is adequately staffed then most likely someone from your units will get pulled to go somewhere else to cover and this causes stress, it causes burn out and it causes employees not to want to come to work. So adequate staffing for each unit. We can understand when someone is sick like that but not a everyday thing, not a every week, every month ongoing continuation. So we need to address staffing for all tours at the VA that the veterans will get there adequate patient care. As employees you it is good to work at VA. I believe the VA nurses are dedicated. We enjoy going to work. But when thing are not right then you don't want to go to work. When I am going on at night I wonder what is going to happen, who is not coming in tonight. So these things need to be addressed. And I don't think that they should say, Well we don't have the money to hire people to take care of the veterans. You know this is a government. And there is money. You know there is money, you know. President needed $70 billion to take care of the war. He got it. So there is money out there for us. You know like that. So we want that consideration, that there be adequate staff and we don't have to float. The decision-making. Most often when we get a new concept,

a new procedure, new things have to be implemented the staff nurses do not have any input. It comes from on high so when it gets to us it doesn't work. And then the government is going to spend millions of dollars for equipment and the thing is inadequate. Why? Because nobody took the time to say, Well, you know, yes we are smart but being patient management, you know and associate chief, we're smart, but wait a minute. Let's ask the people who do this to see if the thing works. Let's get some input with this to see if it works. Only take a little while to do that and millions of dollars is spent and now they have to go back and change things or now they want you to work with what they have given you which hamper you. You already short staffed. You already pushing for time. So trying to do these things with inadequate equipment because nobody asks you. You want to know what your teenagers are thinking you got to ask them, got to talk with them, and they will tell you same thing. So we want more decision input. If the associate chief, these people would this, then a lot of things could be avoided do and they could save money and that money could be put towards staffing, see, rather than the drug people getting and the those companies that do these equipment getting it, we could get it. And then next thing I like to address is overtime pay. I would like to see if we could get a separate –

MR. DANDRIDGE:

And you would also like to learn, have time to master the most recent technology before you get into something else; right.

MS. GREEN:

Right.

DR. PATTILLO:

I'm glad that you're comments are recorded. I think your comments are very good. The other thing is we can't mandate respect and cooperation. We can't make people cooperate with each other. Collaborate. Can't mandate that. It is a big problem. So do you have any ideas on how to get that done? We would appreciate that but you can't order someone to respect or cooperate with people.

MS. GREEN:

Communication.

DR. PATTILLO:

Yes, communication and respect and relationships. Thank you so much, Annie.

MS. GREEN:

Thank you.

DR. PATTILLO:

Cecilia McVey.

MS. McVEY:

Good afternoon. I am Cecilia McVey, vice president of the Nurses Organization of Veterans Affairs and nurse executive of the Boston Health Care System. I have been a VA nurse for 35 years this July starting out as nursing assistant, staff nurse, nurse manager, associate chief and now I'm present nurse executive. I want to thank the National Commission on VA nursing for this opportunity to address you. In VISN I, a decision was made to organize a service line structure and a proposal had followed to include nursing staff in the reporting to various non nurse care line managers. The VISN I nursing executive counsel recommended however that those nurses who work in setting requiring 7-day/24-hour coverage remain under the responsibility and the accountability of Nursing. In this era of nursing shortage and need to strengthen nursing links, maintaining this line authority this line of authority should result in enhanced support for nurses at bedside. However not all facility or VISN's use this approach. Across the system nursing staff has reported a negative impact from the services line structure. Some of these outcome have included the dissolution of nursing education support, the struggle to maintain one standard of care, the emergence of several mini hospitals in one medical center which results in inconsistent practices and poor communication for nursing staff. Although each facility is different, some medical centers in VISN I do have a structure supporting nurses' input in decision-making. Most facilities have a clinical nursing practice committee with representation from clinical areas who strive to utilize expert panel staffing methodology incorporating staffing at the bedside in the input into an appropriate mix of staffing. This, however, is not the case in the universities across the country. As we hear from many of our counterparts that in systems that have abolished traditional nursing structure. These nursing executives and nursing staff are concerned that they have little or no input into decisions relating to nursing practices and staffing, as many staff may report to a non-nurse and the non-nurse lack of specific nursing knowledge can carry over to a lack of appropriate review of scope of practice as well as unfamiliarity with the nuances of the Nurse Qualifications Standards and the function of the Nurse Professional Standard Board. This service line structure further diffuses the deployment of nursing staff and the lack of understanding regarding educational programs and competencies are some major concerns across the system. Changes that could be made to ensure meaningful nurse participation in decision-making begins with having the nurse executive designee as a participant on all key VISN and medical center committees. A comprehensive assessment of the impact before service and care line structures on nursing should also be undertaken by central office. Although facility specific, most nursing executives meet regularly with all levels of nursing staff and participate in walking rounds generally report a perception nurses feel that they have input to making the of meaningful decisions. The trust is earned, as was said earlier, not dictated or mandated. The facility as well as network directors and nurse executives need too understand the necessity of supporting the work of nursing. An environment that facilitates their work is one in which there is generally enhanced nurse satisfaction. Facilities that have achieved magnet status exemplify some of the best areas for nurse to deliver care. Staff can be empowered at all levels of the organization, if management allows them to support, the encouragement as well as the time to do this. An organizational climate and structure that encourages and rewards this input is optimal, but as I said earlier it is not possible to dictate either climate or VA can provide better support for structure. Education and training by ensuring a sufficient amount of no

discretionary monies. Currently, many VISN and medical centers have experienced serious financial challenges. For example, over the last several years positions such as the associate chief nurse of education have had their scopes broaden to encompass what was a former human resource function, that of medical control-wide education which has resulted in the diffusion of the ability to support nursing. With the current nursing shortage and turnover of staff there was a need to intensify once again education dedicated to nursing. For instance, orientations could be more flexible and on hand support for new and experienced staff would be more readily available. At the Boston facility we have reintroduced unit based clinical instructors for med/surg and critical care to provide hands on orientation and assistance for both new and existing staff. In order for this to become the rule rather than the exception, VA needs to reemphasize the value of providing support such as this for nurses at the bedside. An additional item of grave concern is the practice lagging or freezing of various positions along with those with nursing. VA leadership needs to continue to emphasize the detrimental effects of lags and freezes on recruitment and retention. The effects of this process can take months to undo and impact greatly on morale. At NOVA's visits held in Washington D. C. this March of 2003, nurses from, various facilities expressed concern over the lack of human resources knowledge and support in the field so as to facilitate the appointment and orientations of new staff in a timely manner. With a dearth of nurse recruiters and a downsizing of human resource personnel as well as retirements, there is now a paucity of manpower, knowledge and expertise to apply many of the recommendations in the VA nursing work force report. Despite the fact that this report is available on the Web site and has been distributed and emphasized to the field at least twice, there are still many stations report that there is not adequate funding support or expertise to take advantage of the strategies set forth in the report. Issues were also raised from a nurse manager at Palo Alto Health Care System. He had interviewed and accepted six RN candidates his ICU and offered the position to all of them. Four of six declined when quoted their projected salaries. Other barriers included the length of time elapsed from formal job offer to the start date which is frequently from two to six weeks. He stated that in Bay Area, many facilities could interview a nurse on a Monday and have them start the next day. Timeliness and ease of appointment in the VA is more cumbersome and dependent on each VA's availability to have the appropriate number and mix of human resources staff and recruiter support to make this happen. With the VA budget demands and the ever-increasing number of veterans needing services many VISN and medical center directors are force to manage their budget by controlling FTEE. We hear of frequent freezes or lags in the hiring of all personnel including nursing. VA nurse executives can and should collaborate with the medical center directors to articulate the dynamics of nurse recruitment and retention and what detrimental effects this can have on the VA work force. It is no surprise so that a recent VA all employee work satisfaction study indicates nurses reported that heavy workload; rotation of shifts and lack of rewards as well as recognition is one of the major dissatisfiers. While NOVA applauds VA's move to succession planning, we remain concerned with the preparation of the future nurse leaders. The VA can additionally attract and retain a quality work force by valuing the work of nursing. Currently, nurses continue to answer phones due to lack of ward secretarial coverage, empty trash, escort patients and provide a variety of activities created by the lack of appropriate attention to support personnel and the value they add in providing support to nursing at the besides. The central issue of concern in VA pay administration is the inadequate budget and application of

locality pay law. Despite enhancements to locality pay law, final recommendations with regard to facility-specific surveys with RN pay are ultimately based on the budget the business and medical centers have to work with rather than on the recruitment and retention issues, as was the intent. Most medical centers have not been willing or able to adjust nurse pay because of the budget realities in the field. LPN and any pay regulation are also grave areas of concern and will require changes the nurse qualification standards. Are not barriers to recruitment and retention but the knowledge and application of the standards need to be enhanced by providing support and education and Consistency to the field. This is currently being done by central office. Although BCMA technology is a wonderful innovation because of the necessity for adequate computer support, medication carts and personnel; this technology has created challenges in the field. The VA needs to be mindful not to introduce now technology without the proper support. In conclusion, the VA is doing many things to impact the recruitment and retention of nurses. The establishment of this commission, the establishment of the VA nursing work force group and the subsequent recommendations recent enhancements to locality pay, changes to the qualification to name a few but these, however, require the manpower, the knowledge and also the will to utilizes what already exist. Recommendations to utilize many of these innovations require also sufficient funds, central office support as well as business and medical center director support. Nursing does not operate in isolation and is understanding of the need to be efficient and effective. Nursing is the key to veteran health care. Without an adequate and prepared nursing work force the VA system which is still largely hospital based, is in peril. Support the work of nursing by adequately funding for education, such as reinstitution of nursing education departments, nurse recruiters, the avoidance of devastating lags and freezes, when appropriate, and the maintenance of support services will go a long way to enhancing a better future for the nurses who care for America's heroes. Thank you.

DR. PATTILLO:

I have one question and that is how long have you been a nurse exec?

MS. McVEY:

About 10 years.

DR. PATTILLO:

So when you got that job did you get trained for that job? Did you go through a orientation?

MS. McVEY:

Yes, there was an orientation provided.

DR. PATTILLO:

10 years ago?

MS. McVEY:

Well, actually the VA used to have an associate chief in our training program, which really needs to be reestablished again. And that was back in

the '80s. I actually was able to attend that, although not a lot of my counterparts were able to attend that. And now the VA is working towards reestablishing education for executive positions and including nurse executives.

DR. PATTILLO:

When you hire your nurse managers -- when you select nurse managers, do they get training to be a nurse manager?

MS. McVEY:

We have in our? Particular facility a quarterly nurse manager development program and in our division we have an annual program for them. We have a preceptor program but certainly enhancements could be done better. I know that Cathy Rick in central office nursing supports utilizing program by the health advisory board across several businesses to enhance that training. So we need to continue to do that.

DR. PATTILLO:

Thank you.

MR. DANDRIDGE:

No questions. I did observe that Ms. Green left the room. And I wanted to apologize to her because I did not realize that she was a 10-minute presenter. I did cut her time short. So I would highly encourage the chairperson that should she desire more time we look forward to it.

DR. PATTILLO:

Thank you very much. All right. Our next speaker is Elizabeth Chopik from Canandaigua.

MS. CHOPIK:

I was interested in your question about the nurse manager mentor ship. Having been in that position, no, there was no training. My name is Elizabeth Chopik. I have been a staff nurse, a nurse manager and day nurse manager at Canandaigua VA Medical Center. I received no mentor ship in the nurse management program. However after six months of being in the position I did receive a four-inch binder, which I was told to read and never read it. That is not why I'm here though. I am here to discuss the boarding process, the qual standards process, and the problems we have with it, not only on the national level but on the local level and the business wide level we need full and adequate representation of the nurses on all levels, and I don't believe we have that presently at our local facility and I know we do not have it at the national level. It is not a process, the boarding process as it should be and the qual standards process is not. It should be by number or something or maybe perhaps this business should have the people in the business rather than have a local process. No names should be used. It should be impartial. Years of experience and knowledge are ignored versus educational letters behind names. This goes for hiring as well as retaining nurses. Personally I have seen nurses recruited. I have seen application divided, the ones did not have Bachelor's and

Master's designations were the letters were returned and not even looked at, which is not fair based on the shortage in nursing we have now. Career advancement for our nurses is very, very difficult. They are very experienced people. They are very responsible people. But because they are not in the limelight they are not in process of improvement plans and they don't always have the opportunity to be on a committee. They are very often overlooked just because they work evenings and nights. Narrative reports are very often given with the forms for qual standards. Very often the forms are not completed. The narratives are four and five pages long and everybody knows oh, I know who wrote that. That is very good. They deserve what they get, you know. Very often the forms are incomplete and the personality issues surface very quickly on those. The evaluations are not in support of the process, the form of the evaluations in the last five years. For instance, if you have four years of outstanding evaluations and all of a sudden one year where you are just satisfactory because the qual standard states that, nobody looks at the fact that you are doing just as much as if not more work than you did four years ago, but you're not given credit for it. They are inconsistent in their evaluations. The recent resources for assistants are inadequate. I could not go to someone and say how do I do this because they didn't know either. It didn't matter if this was the nurse exec who said she read the manual or if I went to the manager who would say, I don't know. It is not my job any more or if I went to a peer, who said I am in the same boat you are in. Nobody knows who to go to. The quality and the interpretations of these standards differs between care lines at each facility. The medical care line and the behavior health care line do not see the same standards the same way. They interpret it to meet a specific vacancy, use it is as a specific RN already has been identified between care line managers and human resources and the nurse executives. Then we have the problem between the care line managers and nurse executives where there are always difference, too. So where the care line manager might feel this person deserves the job the nurse executive may say they don't meet the qual standards. Very confusing. Advancement for nontraditional roles is often through the care line manager. It is often very political by its nature. Positions are redesigned by care line managers to their specific needs for things like risk management, quality management data collection. It doesn't seem to be consistent in any shape manner or form. Positions are created, title are created. The temporary credentials are created by the care line managers. So when you are all done nobody knows who they are, what they do and what their qualifications are. Specialization and certificates for registered nurses and for LPNs and for anyone else for that matter they are not encouraged or rewarded or considered evaluations based on the qual standards. The degree of education is but not a certification. A certification very often requires hour and hours of on-the-job training. Also quite a bit of study is involved with textbooks and education and testing. There is no consistency at the facility that I am at. Certifications are not recognized unless they are politically necessary. An example of that would be the RN case management behavioral health or the case act the certified alcohol and substance about program. The time for education is also very difficult to arrange. However I have seen care line managers explain well someone wants certification just give a monetary ward. Well, that doesn't help because that is put into your paycheck and taxes are taken out and you still don't have the money to pay for the exam that gives you the certification. That is not a very good fix in my book. Tuition reimbursement is very complex. It is not equitable and sometimes care line specific. It is not timely. It is very expensive for someone to go to school and the courses are not always approved by the care

line managers. VA sponsored programs for nursing for degrees are not what the RN wants. They only have one thing to go to and that is the choice. The VA sponsored programs whether they are care line sponsored or facility or national sponsored are very beneficial but that doesn't always mean that person wants to take that. Case in point I may not want to take geriatrics. I may want to do more in psychiatry and it is not recognized. So unless I take what the VA offers to pay for I'm not in the picture. I cannot advance myself monetarily or educationally. That is why I'm stuck. I am one of two nurse managers in the mentally ill program outpatient that I'm working in presently. I believe he left because of frustration of being a care line manager -- one his big frustrations was the inequities of the qual standards. I left my position after six months of arguing. It is a very frustrating when you have nurses that need recognition and you cannot give it to them. It is very frustrating because the process is not equitable or fair, and the politics is unbelievable. Thank you very much.

DR. PATTILLO:

Susan Vickory, Boston.

MS. VICKORY:

My name is Susan Vickory. I have been a nurse for 34 years. And I have been at the Boston VA for 21 years. I have been at Jamaica Plains in an psychiatric acute unit and I have been for the past six months at West Roxbury a crisis stabilization unit. That is because our Jamaica Plains VA closed and is now an outpatient facility, and we're at West Roxbury. I'm also a American nurse association certified in psychiatric mental health but I have an Associate's degree that at the time I got my associate it was three years of college. That was back in 1968. Okay, the reason that I'm telling you about this is because for the past four years I have been the educationally liaison with psychiatry and in that period of time I won a national award from the VA for putting in a program to decrease violence on inpatient units. I also present a violence workshop presentation to new orientees. I present how to handle aggressive patients to psychologist students. I present at UMASS, Boston and UMASS, Lowell aggressive patients and also eliminating violence in the workplace or at least preventing it. And I have also put together a power point presentation for legal innovations for the Massachusetts nurses association. The reason that I go through these is to tell you that associate degreed nurses can have an impact. Now these tasks are in addition to my staff nurse duties, which are now I'm consulting with med/surg patients in West Roxbury for behavior problems, consulting in the emergency department for worse psychiatric patients, and in addition to any patient that we have in crisis stabilization I also teach them and their family about medication follow-up and about their illness. I have been recommended for the past three years to be raised from Nurse II to Nurse III, both by the patient care coordinator and by the nurse manager. The first time that it went to the board I wasn't notified for five months as to when was I boarded. Five months later I received a personnel notification with the names of people that signed but no reason. At the time I was in Northeast University and I was too busy to try to go about filing and appeal and no one helped go about that with me. I want to tell you that the in the Boston area there is a big shortage of nurses and some of the main teaching hospitals are paying experienced nurses $90 or $100,000 a year. It is very hard the believe. But if you want to go into the downtown area, you can make a very large amount of money. The VA is discouraging experienced nurses from staying

with them because they are angry about the inconsistencies of the nurse professionals standards board. The nurse professional standards board is cloaked in secrecy where we are. We don't know who is on it until after we have received a personnel notification five months later. But the worse was that when why nursing supervisor of my nurse manager put in a memo for me to boarded again, I received an e-mail from a secretary that said, Sorry, you're out of cycle. That was it. This angered me as far the inconsistent way the nurse professional's standards board handles experienced, hard working, dedicated VA nurses. Take away the secrecy, make the nurse professional standards board be accountable for the individual nurse who is denied a promotion. I have met all the steps, all nine steps were addressed but I can't even get my evaluation read by the professional standards board. Two memos have gone unrecognized what I want to say is that I would. like to see a union rep be part of the board process. I would like to have an answer as to why nurses are not promoted in a timely way, not five months later. And I would like to say that we be addressed with ways of making Level 3, in order to give us the incentive to keep on because there is no incentive to go back to school in a 24/7 job. Nurs nurse managers make it clear that if you want to go to school you're probably going to need to take a night shift, rather than being able to work out a schedule so that is not encouraged. But what I want to do is I want to make the board accountable to us, accountable to nurses that have been there a long time and have done very good work, very outstanding work in the community. I want them accountable to us, in a timely way. Three years for a cycle is ridiculous when things are moving on as quick as they are. I speak for myself and two other nurses of the crisis stabilization unit that are trying to get Nurse III but have not and that is my personal experience.

DR. PATTILLO:

Thank you. It is recess time. We'll come back(Whereupon, a short recess was taken.)

DR. PATTILLO:

Our next speaker is Mary Murphy, Washington, D.C. VA Medical Center.

MS. MURPHY:

Good afternoon. I'm Mary Murphy from the Washington, D.C. VA Medical Center. And I first want to thank you for the opportunity to speak on behalf of other nurses at the Washington, D.C. VA. I'm a master's prepared nurse. I have been a nurse for 27 years. I have been at the VA now for two and a half years and am working at the mental hospital. And I today I'm the voice of the nursing profession practice committee at Washington, D. C. VA. And we decided to answer the questions how can the veterans administration attract and retain a quality work force. And our committee believes that the veterans administration could best attract and retain a quality work force by promotion and publicizing the strength of the veterans administration nursing service and address factors that do satisfy nurses. And the strength of VA nursing services that we identified are that linked to the fact that the VA health administration is a national healthcare system that has enormous potential for sharing expertise and resources among it many facilities to promote best practices. Computerized medical records facilitate nursing research and serves as a foundation for advancing evidence based practice. Bachelor's degree nursing preparation is

preferred for staff nurse and is a rewarded. Flexible scheduling is available. Tuition reimbursements opportunities are available and bonuses are used to reward exceptional performance. Now in an effort to identify factors that dissatisfied nurses, the nurses the professional practices committee reviewed four surveys done over the past two years at the Washington, D.C. VA. Nursing satisfaction focused on a survey done in2001 that asked nurses to discuss issues leading the nurse dissatisfaction and prevalent issues identified included short staffing, heavy workload, 22 percent; lack of career promotion opportunities or reward, 20 percent; lack of ancillary support, 11 percent; lack of training and education opportunities, 9; lack of nursing inputting into the decision-making, 6 percent; and low pay, 6 percent. Now a review of 29 nursing exit interviews done in fiscal year of 2003, nurses who left between October 2002 and March of 2003 show that 58 percent of nurses leaving VA identified heavy workload as the most significant problems VA nurses face. Another 33 percent identified inadequate working conditions as the most signature problem. A repeat survey done in February2003 attempted to look at how nurses currently rank the dissatisfiers that were previously identified in the 2001 focus group survey. Generally speaking the most common dissatisfiers identified was the lack of a system for fixing things from the bottom up. The results of the survey vary widely from unit to unit demonstrated the importance of the focusing on the dissatisfiers at the unit level. Now a recent informal survey the professional practice committee members indicated that nurses want more involvement in staffing decisions and increased opportunities to participate in the decision-making at the unit and service level and that nurses identified teamwork, high quality patient care, collaboration, flexibility and bonuses as motivators. The survey also found that nurses take pride in providing high quality care. Two other pertinent observations made by the professional practice committee members are that the population we serve has an older mean age than any other health care system and the patient have numerous medical and psychiatric problems. Secondly, although the nursing staff expressed a desire for more involvement in committee meetings and activities that promote professional practice, participation has been historically low. So the take home message from us is that work load is heavy and nurses have little time to do more than care And we attempted to discuss what the for patients. heavy workload is and we feel it is a byproduct of the evolution of the VA nursing. Nursing like daily life is much more complex than it used to be. We used to focus on physiological sub systems. Now we focus on holistic health. Nursing care plans were justifications for intervention Now nursing practice requires us to learn systematically from experience and develop evidence based practice. We once documented care and audited medical records and now we manage information. Not long ago we communicated indicated by telephone that had no voice now. Now we have telephones with voice mail and electronic mail, teleconferencing, satellite broadcast. Nurses are bombarded by information at a fast pace. Veterans are becoming increasingly from more diverse cultural backgrounds and we work alongside employees from different parts of the world requiring sensitivity and respect. When he practicing individualized care, we need to tolerate more ambiguity in clinical practice and ethical relations. We as nurses need effective teamwork. Effective teamwork involves time and energy to resolve issues that arise from different disciplines and backgrounds working together. Patients are now much more involved in decision-making about their treatment and nurses need more knowledge about that. So, we're proud health practice has evolved and hope to be a part of the continuing evolution of nursing practice in the VA. Our recommendations are to increase publicity about the positive aspects of the VA system and the

nursing services in particular. Enhance staffing by developing a user friendly accurate patient classification system to truly determine patients staffing needs and encourage the use of staffing models that take into account case mix, complexity of clinical decision-making and the quality of patient outcomes. Promote the management at all levels to support empowerment and provide coverage to allow more staffing involvement. Veterans affairs nursing leadership needs to insist that the hospital resources supporting employees in the delivery of patient care and ancillary service work effectively 24 hours a day, seven days a week because veterans affairs nursing is and will continue to be limited by the system it functions within. We also recommend that -- well I can give you some examples of problem areas with regard to that last recommendation but I will do it off the record. Improve career ladder programs to include promotion and awards available to bedside nurses. Provide nursing leadership education to advance skills and enable promotion from within the VA employee pool, and provide coverage to enable staff nurses to participate in the many educational opportunities available. Thank you.

MR. DANDRIDGE:

I'm interested in the comment that would only be made or the suggestion that would only be made off the record.

MS. MURPHY:

Since it was a problem area --

THE COURT REPORTER:

Do you want me to go off the record?

MR. DANDRIDGE:

Well, I think the real value is to have a record. Personally, if it is something that you feel would reveal that agency and its nursing profession from all levels would benefit from, I really encourage you to make your suggestion on the record.

MS. MURPHY:

Well, one of the examples of the problem areas I just mentioned before I came up here was when I was recruited into the VA two and a half years ago I did not receive my acceptance letter until I was at the VA for at least Two or three weeks And that was not only me, it was all the nurses that were in my orientation, which was about six of us and to expect people to come to the VA and not have something in writing that they are accepted for employment it is pretty unacceptable. I went in because I knew people that worked there and they assured me that everything was okay, but it make it difficult to get nurses in. And then the other problem is then that the pool that you're recruiting from becomes aware that the VA they don't send the letter until after you are there and it just has a very negative impact I think on recruitment and retention as one example.

MR. DANDRIDGE:

Thank you. Timeliness is something that clearly can be improved upon and certainly one of the things that many people talk about is the benefit of

being able to go to the recruitment fairs and being able to offer the position on the spot as opposed to going through fairly protracted process and losing prospective applicants to other institutions who can make the commitment there. So your point is well taken. Thank you very much. And off the record. (Whereupon, a discussion was held off the record.)

DR. PATTILLO:

Annie, are you here?

MS. GREEN:

Yes.

DR. PATTILLO:

We accidentally cut you off prematurely. Would you like to finish your statement? We will be glad to hear you.

MR. DANDRIDGE:

Annie, I am logging you in at 26 after 3. You have six minutes left, if you so desire.

MS. GREEN:

Okay. Thank you so much. To continue presenting my issue and concern of the issue at the VA, my coworkers nursing education. The BSN program we were told they encourage us to have for the RN to have their SBI 2005. Now education is very expensive. You have people working and you have the associate degree. You have the diploma grad that is working at the VA. So what I would propose that we would look at is that we start an in house program for the nurses for the NAs and the LPNs, for those that are working towards their BSN and do it in house. Because currently I'm working on my BSN and what I am finding out now is that when you go to college out there they tell you have to take prerequisite courses. Now you look at the age group within the VA and you have a lot of nurses who want to do that but there are roadblocks that are stopping them from doing that. If you have to take 12 prerequisites that could take you over two years depending on what your financial status is. Yes, we get reimbursed from the VA as you pass your course with a C or above but why not come and help us where we need help. If you start an in house program then a lot of nurses will be able to take that day class for the people that working on the off tour shift and then evening class for the day people. It will be a tremendous response that we could go because we're in the house. At the VA we are a family. We work for the government. We are the backbone of the United States, the country. So therefore if they could help us more in this area, help us more because we give ourselves because we are caring people, and we want to be educated. But it is not easy if you are a mothers by yourself with three or four kids to feed then where are you going to get the money. I took a three credits course. It cost me $530. So that would help us if you would consider doing that in house. You know, instead of reimbursement just pay qualified people to come in and teach us right there at the facility a day or two or a weekend. We could do it right there and that would be a tremendous response for us. That would help us a lot. So that is it. The money is there. It is there.

DR. PATTILLO:

We have two members on our commission who are there because of school affiliation, Dr. Phyllis Hansel and me in terms of school affiliations.

VOICE:

And I know that AACN has a program where they do come on site to different VA medical centers to do the teaching on site. I just wondered about the possibility of online courses for nurses and so just as you all go back on and do your own planning and suggestions that's available. We do have online classes.

DR. PATTILLO:

That's a feasible thing for you. Just wanted you to consider that.

MS. GREEN:

Talking about the general population within the house that a lot of people don't want that. They are afraid the computer. You know, a lot of older people. It is new technology so you know they do better with teaching hands on.

DR. PATTILLO:

Thank you.

MS. GREEN:

It would save money if you do that plus you will get an educated nursing staff. So it benefits work both ways.

DR. PATTILLO:

Okay. Karin Thompson.

MS. THOMPSON:

Good afternoon. My name is Karin Thompson. And I'm an advanced practice nurse in psychiatric clinical specialist in psychiatry at VA Connecticut. I'm going to be advancing some ideas related to recruitment and retention specifically, educational benefits, promotion and advancement. I believe that the VA has the resources to attract and retain a quality work force but does not use them consistently. The ability to advance in the system currently resides only in the management track. This is not always been the case. In 1984 I joined VA as a head nurse at intermediate grade Nurse II. I was impressed with VA's progressive system for advancement according to the "CARE" model different from cares of today. At that time, it referred to clinical administrative research and education tracks. For first six years at that VA I received two special advances for achievement, two special advances for promotion, performance and eventually a promotion from Nurse II to Nurse III, senior grade. In 1989 I left the VA for a nurse manager position in the private sector as the time for the closure of my unit approached. After working 2.5 years in a managerial position with clinical administrative and fiscal responsibility I made the decision to

return to school in order to increase my job opportunities at the VA. After moving, I was accepted at graduate school and obtained a part-time position at another VA within the state of Connecticut. Soon after I learned that I could not be boarded and my previous grade as my OPF was lost. Reproductions, which I had were not acceptable. During my last year in graduate school I was finally boarded, using a proficiency that barely detailed my staff position and professional history life. The VA and the old research that I had undertaken during that time was not addressed nor the advanced practice clinical work that I was currently engaged in. I was dropped to Nurse II, the grade that I had entered into nine years before. Within another year and graduation the salary tables were revised, and I now found myself dropped to Nurse I. This is a true story. Despite working an additional 2.5 years in a progressively more responsible management position and obtaining a graduate degree from the Yale University, I had been drop from the to the lowest grade. I kept on submitting copies of my OPF and the work that I had done but was disappointed to find I was again not promoted when I obtained a full-time position as s nurse clinical specialist and director of a treatment program. After filing an administrative grievance I was moved up to the Nurse II level, but not Nurse III. Continuing my education I obtained my clinical specialist certification and my APRN license. Again I did not receive my previous grade, much less the step increase for a bonus. After four and a half years and submission of four reproduced OPFs I sought legal advice. I was then given back my Nurse III grade but without the associated cost and loss steps in wages over the years. In August of 2002, I realized I was now in the same grade and step that I had been in April of 1989, 13 years later. The cost of graduate school tuition, lost wages was over $160,000. As I approached age 50 with a child in college I still have three years left to pay off my own student loans. There are no programs regarding loans for nurses who have been in the system some time. The cost of obtaining a degree to become an advanced practice nurse is very high. My malpractice insurance premiums increased times 10 when my role as clinical specialist expanded to one with prescriptive authority. It is unfortunate the VA nursing does not value the work of those who are sought to attain higher levels of education, practice, liability, and responsibility. This may also have the effect of deterring younger nurses from pursing their education, as there are few meaningful incentives in a clinical track. The appreciation for our veteran patients is not enough to offset long hours without compensation, as we're salaried, coupled with the increased volume of liability of treating sicker patients in an environment with decreasing resources and minimum support. I do have some recommendations. Nurses with graduate degrees in nursing should be brought in at Nurse III level regardless of the amount of experience or time in a particular BA. The education role responsibility and liabilities of the position should be the determining factors. Nurses with graduate degrees who attain an APRN should receive an additional two steps within their grades similar to the current practice of nurse managers. Three. The amount of education per year for advanced practice nurses should be doubled. The allotment currently shows it is the same at some VAs which is not reasonable given the certification is optional for some nurses, yet a practice requirement for others. $400 per year in educational assistance is insufficient to pay for 30 hours per year given 50 percent must now be ANCC approved. Four. The membership of the nurses professional standard board needs to be rotated every year and APRNs need to have a say in who sits on that board. Number five, APRNs should have a separate nurse professional

standard board without management members sitting on it. Six. APRNs should have a separate pay scale. Seven. APRNs should have the ability to advance to Nurse IV without going into management. Having done both it is my opinion that advance practice nursing is more difficult as a primary provider. Eight. Locality surveys should include APRNs in the community. I don't believe that is currently done. Number nine. Incentive programs for retention should be expanded to include current long term employees. I'm talking about loan repayment there. It seems as though the focus is on recruitment of new employees and loyal VA nurses who have been with the system a long time, stuck with it during all the hard times are not valued as new people are. And so grades earned should accompany employees from VA to VA and they should not be forced to starts all over again. And I just wanted to say thank you for allowing us the opportunity to share our thoughts and ideas in front of the commission. Thank you.

MR. DANDRIDGE:

Your comments or recommendation about grades accompanying employees from VA to VA, I guess I can only say that does not happen now or –

MS. THOMPSON:

Not at the VA I'm currently it does not. There is a sense that one has to put in their time at that particular VA, in order to earn whatever grades you may have earned previously. You know you might have met the standards 10 years previous, but you know you might have to do it again. You are speechless.

MR. DANDRIDGE:

Yes. So much for one VA.

DR. PATTILLO:

Okay. Thank you, Karin.

MS. SOULE:

Good afternoon, Ms. Chairperson of the National Commission on VA Nursing. My name is Marie Soule and I'm vice president of the National Association of Government employees, Local 187 that represents over 300 nurses employed at Veterans Affairs Medical Center in Brockton/West Roxbury. On behalf of the nurses we represent I want to thank you for conducting these hearings and granting us the opportunity to participate in this process, and for allowing us the ongoing dialogue by offering views gained from firsthand experiences. I appear before you today to address and comment on the veterans affairs performance programs concerning the peer review process, promotion, recognition, respect and reward, and pay. These programs have a major impact on the recruitment and retention of the nurses in the VA and will determine whether the VA will fulfill its mission to attract the best and brightest candidates within our profession. I believe that my 15 years as VA employee gives me a unique perspective recruitment and retention issues. The growing shortages of skilled professional nurses have continued to be the most important issue facing the VA. According to recent American Hospitalization Association's release, 126,000 nurses are needed just to fill current vacancies

throughout the country. This shortage is predicted to worsen with staffing needs increasing 21 percent over the next 10 years. The present lack of registered nurses available to care for our patients will also be negatively impacted by the projections that largest portion of our society the baby boomers are advancing in age and will require additional medical services. Many local states and national programs have begun to educate, recruit, retrain and retain nurses. These programs will compete with those directly. Registered nurses in the VA comprise the largest segment of health care employees. Recognizing this, the VA in 2002 charted a nursing work force planning group to address the current and future shortage. A call to action-VA's response to the national nursing shortage was the result of this effort. Since the study was conducted numerous strategies have been recommended to meet current staffing needs, such as flexible shifts and recruitment bonuses. Other initiatives are needed to improve educational opportunities such as tuition reimbursement, scholarships and alternative learning options to attract men and women into nursing and to prepare for the future work force. These actions by the VA also serve to attract those of whom are unable to afford the cost of higher education or who are facing a thinning job market or life career change. Supporting the educational process Is a viable way to ensure professional preparedness while increasing the base of the health care work force. We applaud the VA for their efforts in this area. However, offering loan forgiveness only to those nurses who are potential employees overlooks and marginalizes the dedicated VA nurses who have been a part of the system during the lean years. It seems to make more sense to keep nurses who are already are employees not only because of cost of hiring and training but certainly for continuity of patient care. Many private and public employers recognize the value of traditional knowledge. Retention of professional staff facilitates the development and professional expertise as we move from novice the expert. Work environment that affords professionals a flexible schedule is more conducive to family life and a satisfying personal life will add loyalty to the institution.

The recommendation of the nursing work force planning group that have been made and the changes that have been instituted have been encouraging although in some cases low and at times frustrating. I know that you're aware that the nurse staff and most importantly veterans are closely watching how the veterans' health administration is continuing to translate and articulate a call the action. VA's response to the national nursing shortage, I had been invited two years ago by the associate director of nursing/patient service to observe the Nurse Professional Standards Board. As and observer of the board proceedings I adhere to the same level of confidentiality as did the voting members. While observing the process on many occasion I noticed that several inconsistencies existed between the board chairs. Sometimes they would be clarified by calling the board's technical's advisor for guidance. I recently attended a board meeting concerning the promotion of a nurse manager. The chair wanted to promote the nurse manager on the same criteria that they had denied numerous staff nurses on the previous board. When a board member questioned the standards the chair made it known that this was a manager and deserving of the promotion merely on the fact that it was a manager, even though the manager did not meet the criteria. I recommended calling the technical advisor and was told, you need to be quiet. You are an observer and not allowed to speak. The chair, also a nurse manager, clearly set the tone and made it uncomfortable for the rest of the board members to question qualifications of the standards. I shared this with the associate

director of nursing/patient service. Shortly afterwards I was notified by memo that I was no longer allowed to observe the board. When I questioned the program director of the department of veterans affairs at headquarters in Washington why I no longer could observe the board, she told me it was inappropriate and would not elaborate. In theory, the Qualifications and Nurse Standards Board hold much promise but in reality the system has failed to provide a fair and consistent means of promoting nurses. The system blends a vague set of guidelines and written proficiencies that is an interpersonal interpretive process that is peer review. The system although intended to be fair has broken down many of its own and not lived up to expectations. Written proficiencies, for example, are often traded among staff and as a sort of guessing game as to what magic words need to be articulated to advance to the next grade level. One's chances for promotion is more dependent for their ability to write eloquently than in meeting all the necessary criteria. Only those who are fortunate to possess the skill or have a nurse manager that does will get promoted. As with other template mechanisms once a set of proficiencies passes it is quickly used by others seeking the same level of promotion. The guidelines that I addressed to the degree that they exist at all are perceived as just vague and nonstandardized enough as to how out the sort of differential interpretations that drives the last element peer review. As with the best laid plans of mice and men, so goes the last element of the process where the chair and members of the board decide whether in their opinion the candidates seeking a promotion has made the grade. On the positive side the system intended that employees of equal status and station make the promotion judgments but in reality the system will often times fail in its objectives. Nurses are often frustrated over the lack of accountability of the Nurse Professional Standards Board. Many times nurses are not clearly informed or educated as to why they have been denied promotions and what it is specifically that they need to accomplish or provide in order to meet in standards. Most nurses believe we need to abolish the Nurse Professional Standards Board and follow the private sector practices, including giving yearly raises to nurses who are working at satisfactory levels and the establishment of pay grades based not only on suggestive or ad hoc determinations but rather on objective and duplicate measures. Ultimately this would end potential bias board recommendations and improve morale. In the alternative several changes need to be made to the current boarding process, both in structure and practice, if it is to gain acceptance including the expectation that the board will drop the secrecy and include our union representatives in the meetings. In the end many of our constituents feel that peer review process is favorably flawed and beyond repair. Thank you.

DR. PATTILLO:

John Albenese.

MR. ALBENESE:

Good afternoon. My name is John Albenese. I'm a staff nurse assigned to the VA health care system. I would like to thank the commission for granting me the opportunity to express my feelings and concerns regarding the status of VA nursing. I have worked at Perry Point Division of the VA Maryland Health Care System since 1976. The perspective that I bring to you today is the perspective of the union president who spent over 20 years advocating for VA nurses. I brought some examples to share with

you, explain some of the them that we have in addressing things such as peer review, evaluation system, the ability for nurses to be involved in decision-making, among other things. SEIU Local 1998 in the VA Maryland Healthcare System completed a collective bargaining agreement in October 1999. The contract represented a willingness of local management to address important issues to our nurses. The agreement set forth provisions to improve nurse satisfaction and assure quality patient care. The contract had the blessings of our division director, Division five as well as the local medical center director. Recently management has given us notice to reopen our contract. During our initial bargaining session it became clear that VA central office has requested our director to open the contract with the directive to remove any article in the section covered by USD 7601 or 7472. Our local management which included our chief nurse executive and all nurse executives -- we're a integrated system of clinical centers and services lines. All nurses executives as well as our chief nurse executive readily admitted that our collective bargaining agreement was fine and that they had no problems with it. Articles deemed inappropriate by VACO included providing nurses an opportunity to participate in clinical decision-making, outlining non nursing duties, provided more uniform peer review, and other issues. The union had never filed a grievance on any of these articles during this time that the contract was in force. I think it is important to also mention that VACO did not evaluate the success or the failure of their contract. They simply chose not the permit our director to address the concerns and issues we face in providing quality care and job satisfaction. Nurses across the country are tired of collective bargaining. We're competing with health care organizations that are progressive. They pay more, they provide good work schedules, they agree to safe staffing ratios and you're taking the steps that are need to address the issues of nurses in an attempt to recruit and retain the nurse work force. There seems to be a considerable amount of paranoidance on the part of VACO concerning local management working with its employees to address issues of concern and promoting a good work environment which is able to recruit and retain nursing staff. The real threat to the mission will be the inability to VA to recruit and retain competent nursing staff due to substandard working conditions. The agency will become increasingly more dependent on agency staff, costing more and providing less care to our veterans. I have brought several examples of the exceptions that were sent back to our contract that I would like to enter into the records. It would take two long to actually read them. But I can very quickly go over the issues that are permitted. And they pertain to things such as schedules, work schedules. Reasonable amount of time off, reasonable weekends, times between shifts and tours. Having a process for peer review that is fair that allows for the board to be changed periodically. And also puts a system there to ensure that everyone gets a proficiency yearly and everyone gets awarded yearly which wasn't happening in our facility prior to that. There also is a resistance on the part of central office to understand that nurses need to have input into the amount of caseload review. Our nurses that work in outpatient areas, nurse practitioners the caseloads they carrying are unbelievable. Many of them are assigned less time to provide care for their patients than I have to talk to you. I had two recommendations. The first is I will encourage the commission to recommend that central office re look, revisit their stance on the issues outlined in the U.S. code for Title 38. I would encourage them to allow managers at the local facility to work through these issues with their employees. I would also recommend that Congress change the law to exclude or at least limit the amount of

restrictions placed on registered nurses within the department of veteran affairs. I would recommend abolishment of the current law and I also have a copy of the law that I would like to see passed. Thank you.

DR. PATTILLO:

You know the comment you made recently management gave notices to reopen our contract. What year; was that in 1999?

MR. ALBENESE:

1999 the contract was finished. Recently was September of 2002. Our history with the VA at Perry Point is the contract there is usually good for about10 years, before it come up for renewal. So, it was a shock for us that it was being reopened.

MR. DANDRIDGE:

One of the things that I would appreciate your perspective on is you described a situation and work environment which seemed that it was very positive, very team oriented and worked. As you listened to some of the other testimony you occasionally hear exceptions or examples of situations where you have just the opposite. So then it raises the challenge of how much local prerogative would be more beneficial versus how much more of a standardized national approach to doing things would be more beneficial. Would you comment on that? I mean obviously you know one side doesn't always fit all but you know you characterized a situation that I think may involve the union and would like to see replicated everywhere but I was also heard others talk about things that we probably wouldn't want to replicate everywhere. Where is the balance?

MR. ALBENESE:

I think that with respect to patient's care the issue is that pertains to nurses. What keeps nurses happy? Clearly we're never going to be able the negotiate wages. We're not going to be able to negotiate benefits. The kinds of things that are near and dear to us is having time to take care of patient, reasonable workloads, and reasonable work schedules along with the list that all my colleagues have shared with you. A lot of those things I think can be addressed at the national level, with enough room in the system to be adjusted at each facility. I think there has to be guidelines established. I'm the one taking care of the patient. You don't want to hear from me. I don't have right to tell you that what we are if we are not meeting the care. Those have to be dealt with. I think in order to open up for everyone I think that initially there has to be a stance and that's why I think the overall solution to some of these issues is to get Congress to change the law.

DR. PATTILLO:

Thank you. We have finished our list of 10 minutes oral testimony. We'll now go our open form. Our first speaker is Kathy Helnick.

MS. HELNICK:

My name is Kathy Helnick. I'm an LPN at the Clarksburg VA medical center in Clarksburg, West Virginia. I have been an LPN for 15 years.

My main concern is that the VA, to the extent it has acknowledged the staffing shortage regarding the problems as solely one of the inadequate shortages of LPNs should be addressed through efforts to encourage greater enrollment of LPN programs. But we must also acknowledge the improvement to improve the alarming working conditions at the VA hospital that are forcing their nurse out the door and jeopardizing patient safety. DVA has failed to create favorable working conditions by treating its staff especially LPNs with little or no respect and dignity. It sends a profound message to not only its work forces but to candidates for enrollment and potential nursing students. Moreover the way its work force but to candidates and enrollment of potential nursing students. The DVA management treatment workload work force ultimately re downs to DVA's desire and capability to honor veterans with the compassionate and high quality of nurse care. DVA stands in a unique compatibility to honor veterans with positions to encourage workers to join the LPN nursing profession as a pool of qualified staff who would encourage and support others to become LPNs. My other concern is staffing levels in the decision makings. A recent articles in JAMA shows that surgery patients have a greater chance of dying after procedures in which nurses have a heavier workload and even before this research came out nurses at the facility knew that if you increase staffing levels you increased the quality of care. Word is out about the staffing levels and we're having a tougher time hiring new nurses. Under staffing is detrimental to nursing staff and the patients. Nurses are not at meetings where the real decisions are made. We just have to live with the results of these decisions and nurses are first and foremost advocates for the patients, but when it comes advocating for needed staff levels at the real decision-making tables we're told just do the piece we can with what we have. I strongly believe that the veteran affairs would benefit from a real revitalized upper mobility program for current staff to encourage them to go into the field of nursing and other health care professions on the verge of shortage such as LPN staff. A sound federally funded upward mobility educational program involves requiring each DVA facility to recruit and fund a minimum number of scholarships for current staff to become LPNs, linking the overall scholarship limits to increase and education causes inflation and reduce the scholarships to one year provided that more senior employees receive preference when the funds are limited. Ensuring the DVA employees who attends school full-time receive salary replacement pay and I would also urge the committee to direct the DVA to work in nursing schools and colleges to provide classes at the DVA facility either in person or through teleconference to facilitate greater participation in the scholarship program. I want to thank you.

DR. PATTILLO:

Karen Harrison.

MS. HARRISON:

Good afternoon. My name is Karen Harrison. I am a master's prepared nurse with advanced clinical certification. I have been a RN for 37 years and have worked at five VA facilities over a period of 28 years. This includes Durham, Albuquerque, Dallas and Lyons VA as well as one veteran center. Though I have witnessed many changes over 28 years, a consistent truth emerged that remains stead fast. The cadre of staff nurses are the backbone of the VA nursing chose to remain at the bedside

to deliver the quality care the veterans deserve, but now an alarming migration of RNs out of nursing into pure management positions is removing our leadership. In addition VA culture and management practices support removing the educated and practice nurse from care of delivery. In my current facility the interpretation of the qual standards supports the promotion of ADN, PSN managers to Nurse III. The master BSN prepared including clinical experience nurses who chose to remain at the bedside are maxed out at Nurse II with no hopes for promotion. They receive yearly reminders that they do not qualify for appropriate compensation. Our Nurse Professional Standards Board which is a peer review board has recommended promotion for some of these nurses put they were denied by upper management. Upper management determined the nurses did not adequately meet certain elements. Those elements that would in effect take them from the bedside. Nurse felt some value under the old system. They met a number of these elements for promotion but never quite enough. Their proficiencies ranged from high satisfactory to outstanding. Under the new qual standards they meet no elements and are rated merely satisfactory. They are shamed. They are demoralized. They are angry. The new qual standards crush the hopes of the veterans care provider. Their commitment to provide educated and experienced care to veterans became the basis for evaluation. For these nurses and for the veterans I ask this commission to influence the VA culture and create management practices that demonstrate appropriate value for direct patient care. This merely begins with the establishment of a clinical ladder that pays the care giver and provides promotion opportunity at least equal to manage the slow erosion of the direct patient care. In addition, working conditions must be improve to deter this erosion. This includes abolishment and mandatory shift location, the establishment of a valid patient care system to support adequate numbers of nurses at the bedside and sufficient support personnel for these nurses. Finally, we must remain vigilant related to how care givers are treated. Recent information exposes boards that effectively extend new hire probationary periods from two years to over three years, the time frame I was hired under 28 years ago.

DR. PATTILLO:

Thank you. Melisse Miklos.

MS. MIKLOS:

Hello. My name is Melisse Miklos. I'm an LPN at the Veterans Administration Medical Center. And my issue is pay. There are LPNs leaving nursing services all together for higher grade jobs within the facility that require less education, less skills and less responsibility. I don't think these jobs are overpaid I think LPNs are under paid, given the education, the license and the valued quality of skilled medical care we give. In our facility there is currently a job posting for a work leader program support clerk. That is a GS 7 target 9. These area are pluses for nurses because of the higher pay, the permanent shift and the lesser workloads with substantial less responsibility and they don't have to fight to achieve the higher grade levels as we do. We are less than the professional nurses but we work just as hard. We're considered non professionals, yet nursing is a profession and we are part of that. Therefore we should be paid for the job we do both monetarily and with our leave as well and treat us as the professionals we are. In our facility there is no guarantee on how to

grow in nursing because you are not guaranteed your job or even a job within the facility once you complete your degree. Further more, all employees within the VA system that are paid annually with the exception of JD employees have their salaries annually divided by 2,080 hours to obtain an hourly rate of pay. But for GS employees it is divided by 2,087 hours which leaves us seven hours short of the our posted annual salary every year. In our facility alone we have RNs that are discouraged from doing patient care directly in any manner. There was even an incident when a worker on the floor where the RN in doing patient care including a bed bath on her evaluation there was a negative comment of unsatisfactory because "She functioned as an LPN because this job is unjust to the nurse for doing her job." There are also substantial higher grade jobs that require only a high school diploma and experience to do to do the job. For LPNs we have a higher education levels and our job requires more skill and responsibilities, a license and continuing education, yet we're paid on a lower rate than they are. Two years ago an LPN in our facility went back to school and obtained her degree on her own and upon graduating was informed she no longer had a job because she wasn't an LPN anymore and there were no opening for an RN at that time. And just a comment to Dr. Donnelly's testimony this morning. In my opinion, the type of degree you have does not make you a better or lesser nurse. Higher education is good but always better as a nurse we learn everyday and the best part of being a nurse comes from the heart. Thank you.

MR. DANDRIDGE:

A statement you made in your testimony that I would appreciate some elaboration on and you may have in fact elaborated on it. I was specifically pointing you to talk about the comment about the 257 hours. I wasn't sure I understood that.

MS. MIKLOS:

For a GS employee their pay scale that starts at GS 1 and continues on up the ladder and then there are 10 steps in each level. The GS employee has an annual salary posted at this level. And when you are hired on as a GS employee you are told this is your annual salary. However you never attain that annual salary because when you divide 52 weeks into the annual salary at 80 hours or 40 hours a week it comes out at 2,080 hours. That is all you can work without doing overtime, shift differential you never attain that annual salary. The current standard is that for GS employees it is divided by 2,087. We cannot find where this came about but it was a law by Congress to divide it out that way which leaves you 7 hours short every year and supposedly you will make it up the next year but you are always short because it is always done this way.

MR. DANDRIDGE:

Okay. I understand. MS. MIKLOS: That is for the RNs and the other employees in the facility it is divided by 2080.

SPEAKER1:

By 2,080. So you have got extra hours you don't get paid for.

Your other comment was relating to not recognizing the initiatives of those that go out and get additional training and then coming back and not having their jobs. I guess you cited an example, I guess of an RN that goes out and gets her degree and she no longer has a position and she can't work in an LPN position but they don't have an RN position.

MS. MIKLOS:

They send them out to the private. They know this during whole time they are going to school to get this degree. And yet the day that you graduate you're told you no longer have a job. You can't function as a LPN and we have no opening for you as a RN. So LPNs in our facility go out to the other jobs that pay as much as some of the Grade 1 RN jobs where at the don't have to proceed to get any higher education. We just had a support clerk who has only got a high school diploma out of the military for a short while who got the job as AOD in our facility and he automatically went to GS 9 and you look at that with no formal higher education, how is that fair? It is unjust. We're the ones that are responsible for our patients. We do a good job. We provide them with the best care, but we're paid the least.

MR. DANDRIDGE:

Thank you.

MS. MIKLOS:

Thank you.

DR. PATTILLO:

Sue Patterson.

MS. PATTERSON:

I am Sue Patterson. I'm from Beckley, West Virginia. I have 21 years of experience in a medical field. The last 12 years have been at the VA as a LPN. I'm glad to see the recent change in LPNs to get their GS 7sZ, but I am a little bit concerned and wonder if it might not be made difficult for them to get this or that it be infrequent. I think that this should be made readily available to them. And they work hard. And they deserve this and even more. As Melisse mentioned, other positions at VAs are GS 9s. They have no education above high school, not as much responsibilities, no CEDs, no licenses to maintain. I think this should be taken into consideration. LPNs should be paid for the experience and the job they do. Nurse's aides LPNs and RNs all should be paid for their experience. When RNs start in the VA they get eight hours of annual leave for pay period, and I'm not knocking them, they deserve this, but I feel LPNs are entitled to this also. We're all professionals in our field, with continuous education hours and licenses. Even though we're not considered as professionals, I feel like at the VA, I've worked as a nurse's aide. I feel they should get the weekend premium pay just as the LPNs and the RNs do. They work just as hard. I agree with Ms. Miklos about the GS employees. Their annual salaries being divided by 2,087; whereas, the RNs and wage grades are divided by 2,080. I think the law ought to be changed. We all work the same amount of hours during the week. We ought to get paid for the same

hours that we work. In conclusion, I myself have recently applied for a job within the VA where I work as a medical supply tech. And the reason that I applied and it is a offer that I am seriously considering it and leaving nursing, is I can make just as much money and have little or no responsibilities that I have now and with all the duties that's being added to the LPN and the other nurses and nursing assistants every day, you don't get a pat on the back, you never get any more money, no more incentive, why should you stay when you keep beating down. Thank you.

DR. PATTILLO:

Tricia Dewit.

MS. DEWIT:

Thanks for this opportunity to talk with you. My name is Tricia Dewit. I am an LPN from Castle Point VA Hudson Valley Health Care Services in Dutchess County New York. My intention for attending this conference is as a voice for many LPNs of the New York region unable to be here today. The VA system is one of the largest medical systems nationally and yet they continue to wear blinders on very large resources for medical care givers, that being the LPNs. Despite fact that LPNs must succeed and graduate New York state licensing exams and boards we still are looked upon as the second class citizens within the work force of the VA system. Having been an active participant over several years in LPN conferences within the VA system I am left after each conference with a sense that despite a true desire on matters of the LPN to offer those skills and knowledge and times statewide, the VA system simply put does not desire to acknowledge this potential gold mine. Our medical training follows that of the RNs though not as in depth as the RN curriculum. However, we're unable to work in a system that caters to and cares to give position and powers to a clerical staff within the VA system that gives them a higher pay salary and voice than the LPNs.

For example: a person cleaning floors within the VA who wishes to switch to clerical HAS area without medical training has a better chance of advancement than a medically, clinically trained licensed practical nurse. Positions are made for these clerical persons at the grade levels of 7 to 9. When the mentor ship program within VA is offered within the educational system the LPNs are denied because the mentor ship program starts at Grade 7. The LPNs can go no higher than a Grade 6-9. We've talked about this within the VA, with out any answer whatsoever. We have talked to our director. Still no answer. The only answer that we do get is that it takes an act of Congress literally to try to help the LPNs, whether it be for advancement or just moving up within the VA. The LPNs do not begrudge the VA staff or the RNs. We acknowledge their importance in maintaining a clear smooth running machine such as the VA health care system. However, with the demands placed on the LPNs for patient health safety and well-being we are the low man on the totem pole.

Recommendations: open up the doors and windows for the LPNs in the VA system. Let our training and education mean something. Blocking the LPNs to only a 6 and perhaps a 7, which is not even clear at this point or just hoping that is not going to be a carrot held over our heads dangling in the future is blocking the future retention of the LPNs for the future. Thank you.

DR. PATTILLO:

Loraine Schneider.

MS. SCHNEIDER:

Good afternoon, lady and gentlemen, of the commission. My name is Lorraine Schneider, and I'm an LPN at North Court VA in New York. I have been an LPN for 31 years, and I have been practicing at North Port serving the veteran community there for 11 years now. LPN grade levels are long overdue. Our role and function has changed over the past 20 years. We have been long overlooked for our contributions. We are a small dedicated group of nurses who like most minorities have little or no voice. I like to point out to the commission a few of the duties that you may not be aware of that the LPNs are performing now at our VA hospitals. LPNs on the units are the medication nurses. That means they give all PO, IN, sub Q, preOp, postOp beds, insulin. They are on telemetry units, they read and interpret EKGs. Where I work in the outpatient care pavilion I do diet assessments. We do incentive form of treatments. We place PPDs. We also have LPNs that are on the IV team. In my area in oncology we have an LPN that starts the IV before the RN administers the hemotherapy agents. So I just wanted to shed a little more light on the actual thing that's why we're asking. We're not the bedside nurse like I was maybe 31 years ago. We have made passing a few meds and doing few dressings changes. We are really a more technical nurse. So I think the LPN really has to be rewritten what we're doing out there. Thank you for this time.

DR. PATTILLO:

We have time for more. Freddie Henderson is on the list.

MS. HENDERSON:

My name is Freddie Henderson. I am a health tech at Castle Point. I'm here today to ask that us as health tech nursing assistants receive the Saturday premium. We work right alongside the RNs and LPNs. We work so we should at least receive the Saturday premium. We work just as hard. We may not have a license but we do have compassion. We have a big heart. Just because of the education we all would like to have that education as nursing assistants or health techs. I work on a spinal cord unit. That is tells me that it is a specialty. Well I like to know what they mean by specialty. Because to me a specialty means I'm doing a job that nobody else would like to do. And as everybody knows that work on spinal cord they are very demanding and it is time consuming. I'm the arm. I'm the leg, okay. So, I think that as a health tech we are 6s but as far as what we have to do, we got to feed them, bathe them. We have to change their dressings. And I would like to become an LPN or maybe go further, but I also means that I some money for assistance. So I just like to see that we as nursing assistants and health techs we are in the family also, and we are not the LPNs so much the bottom of the totem pole, we're way down.

DR. PATTILLO:

Thank you. Martha Cureton.

MS. CURETON:

Thank you. I am Martha Cureton. Good afternoon. I'm glad to have this opportunity to speak to the commission. I submitted a written testimony. I hope you will be able to read that during your deliberations. What I have is a question? At the VA where all of the facilities, the administrators, the other sites of the commission hearings where these are going to be taking place?

VOICE:

You may give testimony. You many not ask questions of the pane.

MS. CURETON:

Okay. I have that question because the facility that I work at I work at the VA health care system. We were not informed that these hearings were going to take place. And I think that answering the question whether or not the directors or the leadership had this information and did not share it with the nursing staff that tells you how much we're valued, how much our opinion is valued regarding decision making. There was one thing that I just wanted to address also. I think there is a feeling among administration that when nurses complain -- well, just even make a negative remark or complain about what is going on it is thought in terms of "You're a cry baby. What's the matter, you can't deal with it. What is the problem?" This commission taking place and giving us an opportunity to come here and speak we're not trying to -- you used the term "whine." That really hurt because that is not we're doing here. We were given this opportunity to speak to a commission that is going around the country and wanting to hear from the nurses that are at the bedside, and that is such a great opportunity because we don't have that locally. You wanted to know what we cared regarding the decision-making processes, how we are a part of that and that is important. That is what we want to be. We want to be a part of the decision-making. Lots of people mentioned here today that decisions are made and give to the nurse and we have to live with it. We have to try to work within the decisions that were made at the top, and sometimes that doesn't always work. And they will have turn and redo it because it is not working because they did not hear from the people that are actually doing the work. We have units opened and units closed and "Oh, this is not going to work." Why? You just sitting down and talking with the nurses or the people that are working on the units could have helped. You may not have even enclosed the one unit and opened another, if it is not a workable situation. And so we're not complaining to complain. We're not whining. We're glad that you're here and that you want the hear from us. And I think that is really why we are here because you want to hear from us. The people locally are not listening. We talk. But they're not listening. But we are glad that you are listening. You want to hear and we hope that something will come out of this. Thank you.

DR. PATTILLO:

Are you an RN?

MS. CURETON:

I'm sorry. Yes, a registered nurse and I work in the quality management, Bachelor degree.

DR. PATTILLO:

Well thank you so much. MR. DANDRIDGE: I don't have any questions. But I will say that I do appreciate the time and the commitment that each of you have made to be here. I have the opportunity to travel quite a bit and I would admit sometimes more often than I would like and on too many occasions my experiences are somewhat akin to never have so many come so far for so little; that's so great an experience. However, this is antithesis of that where you have come, you have contributed immensely and your contributions and your time are of great value and they are to be respected for the professionalism and the decorum that you comported yourself and for the information that you provided to us. And again I would emphasize that you not conclude the opportunity for input here, use the Web site, talk among yourselves, look at he testimony that was given, look at the recommendations that were made and to any extent that you can be as specific in terms of some ideas and thoughts, I don't want to be redundant, but I think that is very important. I think it would be very, very important.

MS. CURETON:

Thank you.

DR. PATTILLO:

I, myself, want to thank all of you for coming and I think what we learned from this particular hearing is the voices of the LPNs are very significant and the APNs that was a big voice here, in terms of your input and the non nursing tasks that you're having to deal with and the fact that nurse managers and the executives need training. And I always like to balance the good and the bad and one thing good and some of the wonderful things that I picked up from all the hearings and the inputs is that there so many expert nurses in the VA that are highly educated with stamina and very innovative, in spite of everything, you can do what you do. To me that is just amazing. I want to just tell that the world about how wonderful VA nurses and nursing is and that you can provide a healthy environment for you to practice and you will just do what you have to do. All you have to have is support and a healthy environment. So, we really appreciate your time and your patience with us and your input and let's just hope for the best and continue to provide us input. We'll work together. We have to kind of weigh everything and we will do our very, very best for you but continue to give us your input. Thank you so much.

(Whereupon, the meeting concluded at5:00 p.m.)

C E R T I F I C A T E

I hereby certify that the transcript of the above hearing is a true record.

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McKINLEY WISE, CM
Dated: May 19, 2003

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